2018

The Role of the Public Health Nurse in Rural Areas of Kerry and Cork

Hannah Healy
School of Health and Social Science, Institute of Technology, Tralee, Kerry, Ireland.

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THE ROLE OF THE PUBLIC HEALTH NURSE IN RURAL AREAS OF KERRY AND CORK.

Hannah Healy

M.A. by Research 2018
The role of the Public Health Nurse in rural areas of
Kerry and Cork.

Hannah Healy RGN, RM,
PHN, BSc (Hons), PG. Dip, H. Dip (PHN)

This thesis is submitted in fulfilment of the requirements for the
degree of Master of Arts by Research at the Institute of Technology
Tralee, Co. Kerry.

Supervisors: Dr Tom Farrelly and Ms Sinead Flaherty
Submitted to the Quality and Qualifications Ireland, May 2018.

Declaration of Work

Student Number: T00071387

Student Name: Hannah Healy

Supervisors: Dr Tom Farrelly and Ms Sinead Flaherty

I, Hannah Healy declare that this Master Research Dissertation is entirely my own work and has not been written for me, in whole or in part by any other person. Work from other sources such as quotations or paraphrasing from published or unpublished work has been duly recognised and referenced using the Harvard style of referencing.

Signature of Student:

Date:

Signature of Supervisor:

Signature of Supervisor:

Date:

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Abstract

The Role of the Public Health Nurse in rural areas in Kerry and Cork.

Healy, Hannah;

1. Institute of Technology Tralee, Co. Kerry.

Aim of Research: To understand and gain insight into the role of the Public Health nurse in rural communities in Kerry and Cork.

Background: Public health nursing is the single largest group in community care, current figure employed by the HSE stands at 1,438. Demographic, changes such as the increase in population coupled with the shift in care from the acute sector to primary care has provided many challenges to the PHN service.

Objective: Whilst there have been substantial reviews on the role and workload of the PHN in Ireland, there is limited qualitative research available on what the role of the PHN entails, particularly in a rural setting. Consequently, the primary objective of this study was to understand the working lives of rurally based PHNs.

Methodology: This study is based on an ethnographic approach using an interpretive paradigm to understand the practice of PHNs in rural areas of Kerry and Cork. A qualitative research design was utilised due to the holistic and humanistic nature of this research, using a combination of solicited diaries and semi-structured interviews referred to as the diary/interview method.

Key Findings and Conclusions: The complex role of the PHN has three facets one of a coordinator, clinician and educator. Challenges to the role of the PHN include the unpredictability of their workload, the environment, staff resource issues, and to the point that the PHN service was “we’re it” the only service available. Operating in a rural area also brought its own trials such as time spent on travelling, transport issues, working in isolation and the paucity of services available. Communication was another important theme, which identified the absence of ICT as an obstacle that hinders progress in the PHN service.
### List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABA</td>
<td>AN Bord Altranais</td>
</tr>
<tr>
<td>ADPHN</td>
<td>Assistant director of public health nursing</td>
</tr>
<tr>
<td>ANP</td>
<td>Advanced Nurse Practitioner</td>
</tr>
<tr>
<td>CHO</td>
<td>Community Health Organisation</td>
</tr>
<tr>
<td>CNM</td>
<td>Clinical Nurse Specialist</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuous Professional Development</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DOHC</td>
<td>Department of Health and Children</td>
</tr>
<tr>
<td>DPHN</td>
<td>Director of Public Health Nursing</td>
</tr>
<tr>
<td>GOI</td>
<td>Government of Ireland</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HIQA</td>
<td>Health Information and Quality Authority</td>
</tr>
<tr>
<td>HSE</td>
<td>Health Service Executive</td>
</tr>
<tr>
<td>ICHN</td>
<td>Institute of community health nursing organisation</td>
</tr>
<tr>
<td>ICGP</td>
<td>Irish College of General Practitioners</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and Communications Technology</td>
</tr>
<tr>
<td>INMO</td>
<td>Irish nurses and midwives organisation</td>
</tr>
<tr>
<td>IT</td>
<td>Information Technology</td>
</tr>
<tr>
<td>NIDD</td>
<td>National Intellectual Disability Database</td>
</tr>
<tr>
<td>NMBI</td>
<td>Nursing and Midwifery Board of Ireland</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>NMC</td>
<td>Nursing and Midwifery Council</td>
</tr>
<tr>
<td>PHN</td>
<td>Public Health Nurse</td>
</tr>
<tr>
<td>RCN</td>
<td>Royal College of Nurses</td>
</tr>
<tr>
<td>RGN</td>
<td>Registered general nurse</td>
</tr>
<tr>
<td>UKCC</td>
<td>United Kingdom Central council</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Dedication & Acknowledgements

I would like to thank Ms Monica Sheehan for the opportunity to undertake this research and Ms Violet Hayes (Cork) who both were instrumental in gaining access to the research sites.

My gratitude to all the PHNs who participated wholeheartedly in this research.

To my friends and colleagues in Killarney area and in Kerry for all their support and encouragement.

To my supervisors, Ms Sinead Flaherty and Dr Tom Farrelly for their guidance, encouragement, expertise and endless kindness.
Chapter 1 Introduction to the research

1.1 Introduction

This chapter provides the background to and an overview of this research study. It will begin with the outline of the researcher's philosophical stance, aims and objectives of the research. The chapter will then proceed to outline the rationale for the research and conclude with an overview of the chapters within the dissertation.

1.2 Researcher’s Philosophical Stance

The researcher is a PHN working in the Kerry area of this Community Health Organisation (CHO) region. Prior to the commencement of this study, the researcher had fifteen years, experience as a PHN having graduated from UCC\(^2\) in 2002 with a higher diploma in public health nursing. Being a PHN in the CHO area, the researcher felt it allowed her to be understood as a 'marginal native', suggesting that one can share similarities and traits with participants but not quite be a part of the circle (Crotty, 2005). Such a position is insightful for an ethnographer to be in suggesting the intimacy of social proximity enables the researcher to understand subtle forms of behaviour, perhaps invisible to the outsider (Bourdieu, 2002). However, Parahoo (2014) maintains it is important for the researcher to guard against consuming a common voice, which this gift of professional closeness affords. Researcher reflexivity was therefore, viewed as paramount as it enhanced the validity of research through offering the reader an insight into the research process without the need to be uncritical (Bourdieu, 2004). The sociology of Bourdieu and Crotty's typology (2005) is utilised throughout the research process. Both often favoured the ethnographic method and using a variety of techniques to gather rich data (Finlay and Gough, 2003; Grenfell, 2012). It is a duty of ethnographers to not only provide descriptive accounts of the data they encounter, but they must also engage in the reflexive process (Henderson and Vesperi, 1995; Fetterman, 2010). The process of reflexivity is an on-going encounter between the researcher and the participants, and as an ethnographical researcher, it is essential to establish openness as it nurtures acceptance of the researcher while at the same time engenders a willingness to share on the part of those researched. (Roberts and Sanders, 2005). Chapter three will elaborate on the concept of reflexivity. Altruism was evident, and the participants saw my

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\(^2\) UCC is University College Cork.
intentions were honourable, genuine and borne out of an interest in their professional practice that moved many of them I believe to help me in my research to present an overview of the role of the PHN service in rural areas of Kerry and Cork.

1.3 Theoretical framework

According to Creswell (2014), a theoretical framework is the theoretical lens or perspective guide that directs the researcher through the study. He suggests that the researcher approach the study with a theoretical perspective most appropriate to collect data, examine information, and interpret findings. The primary concern of interpretivist researchers is to elicit rich, detailed, and first-person accounts of experiences and phenomena under investigation by maintaining both an empathetic and questioning stance (Smith, Flowers and Larkin, 2009). Detailed analysis of personal accounts (in this study participants' solicited diaries and semi-structured interviews) followed by presenting and discussing the themes is paired with researcher's own interpretation, which is an expression of double hermeneutics in practice (Smith and Osborn, 2003). The, ethnographic approach for this qualitative study was through an interpretivist lens and guided by Crotty's typology (2005). Crotty's framework places the PHNs at the centre of the research; therefore, it is the PHNs insight and understanding that give the data meaning. Interpretivism is a qualitative theoretical perspective in which the observer will record and interpret the data while negotiating a subjective viewpoint with the multiple voices of the participants to reveal information that may be minimised by the standard deductive methods of quantitative research (Crotty, 2005; Denzin and Lincoln, 2011; Creswell, 2014). The researcher approached the study with the intention of active engagement within the context of a research purpose and objectives, revealing patterns and themes (Glesne, 2016). The researcher thereby had the opportunity to reveal meaningful information through the qualitative research process, without minimising the input of the participants and which may not have been accessible through numerically driven data.

1.4 Background

Public Health Nursing is the single largest group in community care, the current figure employed by the HSE stands at 1,483 (HSE, 2018a). It was first included on the An Bord Altranais register in 1960, following the amalgamation of three separate services in 1956: midwifery, voluntary district nursing and the nurses employed by health authorities. With
the aim to make public health nurses available to individuals and to families in each area throughout the country. A key feature of the role of the PHN in Ireland is that it has a dual purpose, both preventive and curative (sick-nursing), (DOHC, 2000). It is understood that the role of the PHN is involved in the provision of care at primary, secondary and tertiary level (Hanafin, Houston and Cowley, 2002). PHNs are attached to a geographical area which consists of a caseload of one PHN between 2,500 and 3,000 of a population. The client groups that the PHN work with were outlined in a government circular firstly in 1966 and again in 2000 with minimal change (DOH, 1966; DOHC, 2000). The client groups include, all ages across the lifespan continuum; from the cradle to the grave. One of the major strengths of the PHN service is the universal access to homes, the home visiting service. Demographic changes such as the increase in population has led to an increase demand for the PHN service. This growing ageing population along with the shift in the focus of care away from the acute sector to the primary care area has led to increased challenges to the PHN service to meet this demand, coupled with increased complexity in care as hospital stays are shortening. In recent time’s changes in primary care infrastructure, namely the introduction of primary care teams has influenced how the PHN service operates (O’Dwyer, 2012). It is evident that the role of the PHN is continually evolving to meet the needs of the clients and communities they work in. Hanafin and Dwan O’Reilly (2015) expresses that there is no agreement internationally and there is difficulty in drawing a comparison on the role of the PHN, as most PHNs look after one group of clients unlike the Irish PHN who is unique in this aspect.

1.5 Statement of Problem/Rationale

Whilst there have been many reviews (Burke, 1986; DOH, 1997; Begley et al, 2004) on the role and workload of the PHN in Ireland, there is limited qualitative research available on what the role of the PHN entails, particularly in a rural setting. There is a strong need to examine the role of the PHN delivering care in rural communities. It is proposed that this study will garner information pertaining to the PHN’s view of their role in this CHO area. This will not only give insight into the role of the PHN in rural communities but will generate data which can be used in future planning of the PHN service. In addition to this, Ireland and the Irish healthcare organisation is recovering from a period of economic retraction. Coupled with this has been the moratorium on recruitment which existed from 2009 to 2015 and resulted in a contraction of services and an increased workload amongst PHNs (Pye, 2015). Consequently, it is important to ascertain and understand the impact
that the changing demographic and economic conditions in rural communities have had on the role of the PHN.

1.6 Purpose of the Study

The purpose of this study was to examine the nature and scope of the role, of the Public Health Nurse in a rural area. Fourteen PHNs were recruited, who were operating in a rural geographical area in this region. The study's primary aim was to understand and gain insight into the role of the Public Health Nurse in rural communities in Kerry and Cork. Following on from this aim, the objectives are listed as

1. To identify the unique role that PHNs have in healthcare delivery in rural communities
2. To identify the unique challenges faced by clients living in rural areas from the PHNs' viewpoint
3. To inform policy around the delivery of the Public Health Nursing service in rural areas
4. To investigate the extent (if any) information technologies are being used by PHNs operating in rural areas
5. To provide an opportunity for PHNs to reflect on their own role through the innovative use of research diaries

1.7 Significance of the study

This baseline qualitative ethnographic study was important because the findings will continue to inform on-going practice of the Public Health Nurse, in an effort to implement safe and responsive quality care in primary care settings. The findings from this unique professional group provide a valuable contribution to deepening an understanding of how a PHN functions in a rural setting on both a local CHO level and at a National level. The findings of this study are valuable to help inform future research into the PHN profession.
1.8 Definition of Relevant Terms

The following terms need to have operational definitions since they are utilised in this study.

**Public Health Nurse:** The PHN will focus “on a district or area meeting the curative and preventative nursing needs of the population within the area.” The PHN will be expected to provide a broad-based integrated, prevention education and health promotion service and act as a co-ordinator in the delivery of a range of services in the community (Circular 41/2000, DOHC, 2000).

**Professional Qualifications/Education:** To be a registered PHN with An Bord Altranais, you must have a qualification in general nursing, and in public health nursing itself (one year). She/he must also have a minimum of two years clinical experience in nursing (NMBI, 2015a).

**Rural:** is any area outside of a cluster of a population of 1,500 (CSO, 2016a).

1.9 Dissertation Overview

Chapter one sets the scene, outlines the researcher's own position and provides the background and rationale for the study and outlines the primary aim and objectives.

Chapter two provides a review and analysis of the literature pertaining to the role of the PHN. It begins by providing a historical review of how public health and the development of Public Health Nursing both nationally and internationally are interconnected. It outlines the current state of Irish demographics, and highlights the international and national policies, which all directly influence the role of the Irish PHN. The aim of the literature review was to establish what has been garnered on the role of the PHN and identify the factors that support and inhibit the PHN service and to ascertain any gaps.

Chapter three presents the research approach and justifies the methodology used to conduct this research. A detailed description of the diary/interview method (Zimmerman and Wilder, 1977 which was used in this study is provided. This chapter presents a research timeline which outlines the solicited diaries nature of this research. Within this chapter, the ethical dilemmas that were seen to be of central importance are discussed.

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3 An Bord Altranais, the registration board for all nurses and midwives in Ireland.
Population sample, sampling technique, sample size, methods of data collection, and ethical considerations and limitations, pertaining to the study are all addressed. The chapter also gives a detailed account of the analysis process using Braun and Clark (2006) framework to guide the data analysis and the use of CAQDAS (NVivo 11) to store, organise and aid the data analysis. Reflexivity offered the reader a way to understand my relationship to the participants; it is argued that the research process is not external to the researcher, who is understood as an active agent in the production of knowledge (Holloway and Fulbrook, 2001). Fouche (2015) suggests that reflexivity in the research process renders the objective/subjective dualism inept.

The data from the interviews and diaries are presented in chapter four. It forms the core of the research project and address the central research questions, presents, the analysis and sets out the findings of the study. The chapter begins with an outline of the diary completion rates and returns, and a brief description of the participant profile is included. The data findings are presented thematically, combining data from the diary returns and the semi-structured interviews. Four themes emerged from text coded using initial and process coding with the computer assisted qualitative data analysis software (CAQDAS).

Chapter five provides a discussion on the findings of the participants’ views and opinions on the role of the PHN in a rural area. It also explores the challenges to the role of the PHN and the operative issues that occur in a rural area. While one of the objectives of the study was to investigate the extent if any of the use of ICT in the rural area, communication was another theme to emerge from the data analysis which both supported and hampered the PHN service in the rural communities.

The dissertation concludes with chapter six which provides a summary of the research while at the same time an acknowledgement of its limitations. It discusses the implications and makes a number of recommendations based on the findings for practice, policy, and suggestions for further research.
Chapter 2 Literature review

2.1 Introduction

A public health nursing service has been in existence for well over 190 years in Europe, America, and Australia. This chapter will discuss the progression of public health nursing from its roots to the present time briefly in England and America and in detail in Ireland. When discussing the history of public health nursing, the changes in public health need to be considered as this gave the impetus for its development. "Public health in Europe can be viewed as moving through three distinct eras, the age of environment (1875-1930), the age of medicine (1930-1950) and the age of lifestyle (1950-1990)" (WHO, 2001, p.1). In the age of environment, the focus was to improve sanitation, have drinking water and supply food through legislation, such as the 1851 Poor Relief Act in Ireland, and the public health acts passed in 1848 and 1875, in England. The age of medicine was about the discovery of new medications, dealing with infectious diseases such as anti-tubercular drugs and antibiotics and the invention of insulin (WHO, 2001). The era of lifestyle focuses on challenges not treated with medicine alone, where a greater emphasis was placed on how an individual could influence his or her own health. This chapter presents a review of related literature on the role of the Public Health Nurse (PHN) from its beginning right up to the present day. It will also help to gain knowledge into the Strengths and challenges on the role of the PHN in current day practice.

2.2 Search Strategy

A broad search of relevant literature took place on the role of the PHN, a variety of research databases were accessed including CINAHL, Science Direct, Cochrane, Academic Social complete, PubMed and Ebrary. Additional resources utilised include ResearchGate and the HSE, DOHC, ICHN, NBMI websites. Attention was given to current material in the last ten years, however due to the dearth of material and the nature of this study, literature is also included outside of this period as it remains relevant. When using the databases, limits were set to ensure focused searches and to material where the abstract was available to review to facilitate for the inclusion process. Keywords combinations which were used were: role + PHN + Ireland. Inclusion criteria included: relevance to the research, nature and quality of the publication, year of publication, peer-review article and the number of citations from the publication.
2.3 Irish Health

This introductory section provides a brief overview of the demographics of Ireland and then goes on to discuss the healthcare system in Ireland.

2.3.1 Demography

Ireland is a member of the European Union and the third largest island in Europe. The country is made up of thirty-two counties; twenty-six, governed by the Republic of Ireland and the remaining six in Northern Ireland governed by the United Kingdom. According to the latest census figures (CSO, 2016a). Ireland has a population of 4,761,865 people and the density of population is 70 persons per square kilometre up from 67 persons in 2011, with the density average of 2,008 people per square km in urban areas and 27 per square km in rural areas (CSO, 2016a). In Ireland 637,567 people are over 65 years, of the total population, 156,799 live alone representing 26.7% of the total. The figure is up 19.2 percent since 2011, making it the fastest-growing cohort, leading to increased demand on health services (CSO, 2016a). A considerable percentage of the elderly 44% live in the rural area which makes the delivery of service more challenging for PHNs (Nic Philibin et al, 2010). The life expectancy for females is 83.5 years and males are 79.3 years. Ireland has one of the highest proportion of people among the European states living in rural locations at thirty-seven per cent of the total population; the largest increase in rural population was in Cork County with an increase of 6,946. In rural areas, there are more men than women in the 45 to 79 age group and the reverse is true in urban areas which may influence the demand on the PHN service. The population of Ireland has been getting steadily older since the 1980’s. The average age of the population in 2016 was 37.4, up from 36.1 in 2011, a rise of 1.3 years. The highest average age at 40.2, was in Mayo and Kerry. In rural areas, a peak can be seen at age 45, and at age 8, reflecting a more family-oriented population structure. The decline in persons aged 19 to 25 years in rural areas, internal migration as young adults move away to study and work, is a strong feature of the rural population which can cause a breakdown in communities (CSO, 2016a) see Table 1 (overleaf) for a synopsis.
Additionally, the population in Ireland is young 21.4% under the age of 15 (CSO, 2016a) and still growing compared with Europe. The Birth rate is 14.6 births per 1,000 populations (CSO, 2016a) the highest birth rate among the European Union countries in 2016. There is an increase in the number of young children living in flats or apartments since 2011 with the number rising from 18,262 to 29,689 an increase of 62.6 per cent. Children living in flats and apartments account for 5.4 per cent of the total of 5-12-year olds in private households in 2016. Almost a third (30.7%) of primary school children were living in rented accommodation in 2016, up from 28.7 per cent five years earlier, accounting for 168,878 children. The total dependency ratio increased from 49.3 per cent in 2011 to 52.7 per cent in 2016, a rise of 3.4 percentage points. Dependents are defined for statistical purposes as people outside the normal working age of 15-64. See Appendix A, for a synopsis of age changes from 2011-2016. The relevance of these statistics demonstrates that the young and the elderly population, the two most assessed age groups by PHNs (Byrne et al, 2007) are enlarging therefore suggesting an increased requirement on the PHN service, with 44% of the population in Ireland being over the age of sixty-five and living in rural areas (Government of Ireland, 2012).

2.3.2 Health Inequalities

Currently, Ireland has many health inequalities. “Health inequities arise from the societal conditions in which people are born, grow, live, work, and age” (WHO, 2013, p.13). Social, economic and environmental conditions in which people live strongly influence health. Poverty levels are not decreasing, the national average is at (16%), 19% of the rural population were at risk of poverty in 2016, compared to 15% in urban areas, (CSO, 2016b). The causes of rural poverty are similar to the causes in an urban setting (Commins, 2004), where some groups of the population are at a higher risk of poverty and social exclusion, such as the unemployed (41.9%), disability (39.1%) and those with

<table>
<thead>
<tr>
<th>Area</th>
<th>Highest age group</th>
<th>Lowest age group</th>
<th>Gender</th>
<th>Total population</th>
</tr>
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<tbody>
<tr>
<td>Rural</td>
<td>8 and 45+</td>
<td>19-25</td>
<td>More male</td>
<td>37%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>than female</td>
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one adult who had children under 18 years of age (40.2%). Children between 0-17 years of age have an overall risk of poverty of 19.3% (CSO, 2016b). Likewise, people who were born in a different country than the one they reside in migrants and ethnic minorities (WHO, 2013; CSO, 2016b). Poverty in rural areas can be exacerbated by the lack of employment creation and job opportunities which is much less than urban areas, leading to income inadequacies of rural households (Commins, 2004; IRL, 2016). By the nature of the closure of many rural services such as Post offices, shops, banks and Garda stations, living in a rural area necessitates car ownership which can cause further financial strain due to the lack of public transport (IRL, 2016). Lack of public transport in rural areas also affects access to services such as childcare and educational opportunities (IRL, 2016).

The relevance of the above research has shown that poorer socio-economic groups have higher rates of infant mortality, live less healthy lives, are more vulnerable to illness and die younger (WHO, 2013). Ireland, who has the highest proportion of children in the European Union; nearly 11.2% of these children live in poverty and a further 18.6% are at risk (CSO, 2014). The national target by 2020 is to lift over 70,000 children out of consistent poverty (Social Justice Ireland, 2017). While obesity rates for all children are increasing a recent report from the National Longitudinal Study of Children found that girls, particularly from less socio-economically advantaged households are more likely to be overweight; 18% from professional households increasing to 38% from semi-skilled and unskilled households (Layte and McCrory, 2011). Mental health issues, suicide, accidents and poor physical health are all significantly higher in lower socio-economic group (WHO, 2013). Older people, those living alone in rural areas and those engaged in agriculture suffer higher levels of social isolation than the general population.

Comparing people in the highest and lowest socio-economic groups, those in the lower socio-economic groups findings show that standardised mortality rates (per 100,000 population) are higher among unskilled workers (790) than professionals (456) and higher among those who live in the most deprived areas (804) compared to those who live in the least deprived (608). Life expectancy at birth for males living in the most deprived areas is 4.3 years less and for females is 2.7 years compared to those living in more affluent areas (IMO, 2012). Prevalence of chronic illness is higher in deprived areas, the incidence of stroke is 2.5 times higher and diabetes is 1.4 times higher than in the least deprived (IMO, 2012) which suggests increase demand further on the PHN service.
Social inclusion is vital and the PHN service provides a range of interventions for those who are more likely to experience health inequalities to improve health outcomes, including additional home visits, practical support such as home help, referrals to the family support service and acts as their advocate with housing officials, community welfare officers and charitable organisations such as the society of St Vincent de Paul (NDPHN and Shannon, 2014). The government strategy to work against poverty is the updated National Action Plan for Social Inclusion, 2015-2017 (Department of Social Protection, 2016). This gives commitments by the government to reduce poverty using the lifecycle approach and to focus on inequities. The ability of the PHN service to work with communities is acknowledged in the Healthy Ireland strategy (DOH, 2013a) and supported by Nic Philbin et al (2010). Social inclusion works across a range of statutory services in partnership with the community and voluntary sectors, to improve access to health services for disadvantaged groups.

2.3.3 Healthcare provision and current Health statistics in Ireland 2017

Health policy and performance have been important high visibility political issues in Ireland for many years. There has been sharp criticism of the Health Service Executive (HSE)\(^4\) services are unseen, huge variations in what is available in different parts of the country. The development of expert centres based on best practice in larger units has led to widespread opposition from local communities who fear they will be left with limited services and have greater distances to travel with poor transport infrastructure (Giltenane, Kelly and Dowling, 2015). The Taoiseach and the government parties argue that financial investment is at record levels and every effort is being made to progress to more an efficient and effective service. Ireland’s public spending on health in 2014 was almost 10.1% of government expenditure, one of the highest levels in the European Union (DOH, 2016).

Despite this high expenditure rate, Ireland has some of the worst health outcomes among advanced countries (DOH, 2018) for example in some of our communities, life expectancy for the Traveller group, Ireland’s main ethnic minority group is significantly lower than the national average 61.7% which is 15.1 years lower than the general male population (All Ireland Traveller Health Study Team DOH, 2010) and just 3% are over

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\(^4\) The HSE is the organisation that provides all of Ireland’s public health services in hospitals and communities across the country and is divided into 7 hospital groups and 9 community Healthcare areas.
Traveller infant mortality rates are 3.6 times higher than of the general population (DOH, 2010). Ireland has a very low breast-feeding rate which is implicit in the lower socio-economic group. Breastfeeding rates in Ireland according to the WHO (2013) statistics are one of the lowest, 15% of children are exclusively breastfed for the first six months compared with the global average of 38% and the European average of 25%. Professional support is known to considerably lengthen the duration of breastfeeding (Britton et al, 2007) and a study in 2011 found that the PHN had a positive influence and was the main source of professional support (Tarrant et al, 2011).

Ireland has the third highest mortality rate 18.2% from diseases of the respiratory system in the EU and lung cancer accounts for more than one third of such deaths. The EU average is 13.4% (Eurostat, 2015). The highest rate of hospital admissions from Chronic Obstructive Pulmonary Disease (COPD) is also in Ireland twice the OECD average (DOH, 2018), suggesting an inability to manage this chronic disease at primary care level. The death rate from cancer in Ireland is 30% compared to 26% across the EU, the third highest in Europe. (For further information regarding morbidity and mortality statistics see Appendix B). Ireland has the highest acute bed occupancy (94%) in the developed world, which is a key indicator of a system under pressure, suggesting that there are insufficient beds to meet demands (DOH, 2018). Furthermore, the proportion of the population utilising long term care beds is considerably lower than average (DOH, 2018).

Treatment of patients/clients in the community setting could alleviate the significant pressure in the acute sector. According to the HSE capacity review (DOH, 2018) the profile of age groups that use the PHN service is 0-15 (9%), 16-64 (21%) and the 65 plus (69%), so it is reasonable to assume that increases in demand due to the demographic increases will require significant investment. Primary Health Care Reform (DOHC, 2001a and DOHC, 2001b) endeavours to meet the broad health needs of populations in the primary care area, away from the acute sector and remains on healthcare agendas at home and abroad further increasing the demand on all community health personnel including PHNs.

2.3.4 Primary Healthcare in Ireland.

According to the Oireachtas Committee on the future of Healthcare Report January 2017, despite the dominant role of Primary care in the management of the bulk of chronic disease, those working in Primary Care report significant staff shortages to meet this
demand. Another issue identified was the lack of diagnostic services for general practitioners at local level.

There was a general understanding that the best outcomes and value for money can be achieved where much of people's health needs can be met locally (DOHC, 2001b). The integrated care model was proposed as the new direction in the delivery of primary care (DOHC, 2001b). Diagnosis, treatment, disease management and step-down care should be provided at the lowest possible level of complexity with secondary care only being utilised when necessary (DOHC, 2001b). This model of care provision is reflected in the Australian Primary Care model (DOH, Australia, 2013c). Evidence, suggests that concentrated care at primary care level relieves tertiary care admissions, reduces strain on services and provides care recipients with the best possible health outcomes. The lack of integration of care was also highlighted between state agencies, primary and social care services and this needs to be strengthened going forward. To facilitate integrated care, electronic health records and improved IT systems across all stakeholders are an essential investment for the Health Service to promote a fair, equitable and timely service (DOHC, 2013b) The Oireachtas report recognises the need to establish a universal single tier service where patients are treated based on health need rather than on ability to pay (House of the Oireachtas Report, 2017) a tier similar to the NHS in the UK. The critical importance of health promotion and prevention of ill-health was emphasised in the interest of both improving public health and financial sustainability. The report also outlines widespread agreement on the requirement to address challenges in recruitment and retention of qualified staff;

"Further strong consensus on the fundamental role of primary care in managing the clear majority of care needs and a recognition that primary and community services must be in place and able to deliver to bring about a decisive shift away from our current hospital-centric system" (House of Oireachtas Report, 2017 p.14)

Consequently, further research is required in relation to the best means to achieve universal healthcare. Having outlined the demographic picture of Ireland and the current Irish health statistics, the next section will discuss Public Health Nursing.

2.4 Public Health Nursing

The main reasons for the development, of the profession of public health nursing are cited in the World Health Report (2001) as being to crush poverty inequity, to overcome the lack of basic health services, to reduce environment pollution and to control and prevent
infectious disease. The following section will outline the roots of PHN and outline its' subsequent development.

2.4.1 Historical roots of Public Health Care

The roots of public health nursing go far back in history. All people of many cultures have been interested with the events surrounding births, illnesses and deaths (Stanhope and Lancaster, 2014). Individuals from ancient civilisation such as the Babylonians understood the need for good hygiene and had medical skills. Around 1,000 BC the Egyptians cultivated pharmaceutical preparations and built public sewerage systems. The ancient Hebrews have many accounts in the Old Testament regarding aspects of infection control, maintenance of good drinking water and how to prepare and store food. The ancient Greeks related one’s own health to the environment in which they lived. They valued the principles of cleanliness, diet and exercise which are still very relevant today (Stanhope and Lancaster, 2014).

The Roman Empire viewed health from a social and community perspective, during this period women were actively visiting and caring for sick people in their homes (Rosen, 2015). The Romans constructed sewerage and drainage systems, supplied pure water through building of reservoirs and aqueducts. They strongly believed in the regulation of medical practitioners and of discipling those who were guilty of malpractice. With the introduction of Christianity and the belief of looking after others, more emphasis was placed on taking care of the sick. Many religious orders took responsibility for the poor and sick. Throughout the latter part of the Middle Ages, more emphasis was placed on health education and promotion, healthy diets and lifestyles were encouraged (Clark, 2003).

Arabic science was the most advanced up to the 13th century. One of the most famous medieval physicians Rhazes was the first to discover that fever was a defence mechanism against infection (Ofek, 2011). During the Renaissance period from the 14th to the 16th centuries, science helped to grow and advance medicine, medical care was provided to the poor often in alms-houses. The Industrial revolution in the 19th century led to many social changes, whereby in the past a lot of the care provided to the sick was by one’s own family, friends or neighbours, this, became inadequate due to urbanization, migration and increased demand (Stanhope and Lancaster, 2014). Some Roman Catholic and Protestant religious orders provided care to the sick in their homes. Some of these
organisations were the Sisters of Charity whose founder Mary Aikenhead in 1851 practised home-nursing of the sick in Dublin and from 1926 in Cork (Scanlan, 1991). Care was provided to treat the sick and to focus on promoting nutrition and sanitation in their own homes. During the mid-nineteenth century, new evidence evolved regarding the causes of diseases such as bacteria and how the spread of these germs can cause infectious diseases. In 1854, John Snow now known as an epidemiologist published his theory on the spread of Cholera and ways of preventing cholera, one such was to remove the handle off the Broad street pump, which was contaminated to prevent reoccurrence (Cameron and Jones, 1983). More emphasis was then given to prevent the spread of infection on a greater scale. Many lay women who cared for the sick were poorly educated and untrained. With the advancement of medicine, more skilled caregivers were required, and interest was gained in educating these caregivers and so began the evolution of nursing and formal training school (Scanlon, 1991; Fealy, 2005). When exploring the evolution of Public Health Nursing in Ireland it is important to include a wider context, this review will specifically discuss its' origins in the United Kingdom (as Ireland was part of the British empire till 1922) and America as we are historically so aligned.

2.4.2 International Development of Public Health Nursing

The following sections will outline the development of public health nursing firstly in the UK, then in the USA, Canada and conclude with Ireland.

2.4.2.1 UK

The origins of district nursing/public health nursing in the United Kingdom, can be traced back to an affluent Liverpool merchant Mr William Rathbone, who hired a hospital trained nurse to care for his ill wife at home in 1859. Rathbone was taken aback by the great comfort his wife got from a trained nurse despite her not being in a medical environment (Baly, 1989). After his wife’s death, Rathbone employed the nurse to attend the sick poor in Liverpool and within a short period in 1874, he set up a school of nursing to train nurses to provide care in the home with the help of Florence Nightingale (Quaille, 2016). The nurses had 18 months training, 12 months were hospital based, while the other 6 months were community based. The nurses had lessons on improving public health, on sanitation, infection control, child-care of infants and on postnatal care of mothers (; Baly, 1989; Buhler-Wilkerson, 2003). Baly (1989) one of the most prolific historians of the time argues that Florence Nightingale was the pioneer of nursing. Fealy (2005, p.45)
disagrees with this and believes that the “flow” of ideas for nursing did not come from Nightingale alone. Fealy believes that long before Nightingale came along, the Irish Sisters of Nursing in the Crimean War had begun to transform the care of the sick and the poor (Fealy, 2005). The reason their contribution is not visible may be due to the lack of written evidence and the fact that the English Church in the aftermath of the war, proclaimed Nightingale the heroine (Fealy, 2005). In the 19th century, domiciliary nurses in the UK were mostly trained and organised by religious societies, health visiting developed as a separate process from home nursing and became established as part of the UK public health movement of the late 19th century. Its’ roots are believed to lie in both sanitary inspections and addressing infant mortality.

Male sanitary inspectors objected to women taking on their work and medical officers supported the notion of the Health Visitor as the mother’s friend (Davies, 1988). Health Visiting in the UK did not become a nursing speciality until 1962. The early health visitors shared some of the concerns of the United States recognising that the need to address social and environmental factors in improving health, where they differed was that health visiting in the UK was targeted by medical officers to reduce infant mortality, whereas in the US PHNs targeted communities to improve health. In contrast to the U.S. health visiting in the UK appears to have developed with the dominance of male and medical dogma (Craig and Lindsay, 2000).

The National Health Service (NHS) Act of 1946 compelled local authorities to provide a free home nursing service and empowered local health authorities to set up health centres (Sines, Appleby and Raymond, 2001). The notion of healthcare as treating or healing those already sick, maintained dominance over preventative care. The NHS was established on the 5th of July 1948 and one of its key aims was that the health of the whole population would be improved, services would be free at the point of contact, financed by the state, provision of services would be comprehensive and distributed more efficiently. Local authorities’ new role was in health promotion and the prevention of ill health which included health visiting and district nursing. General Practitioners (GPs) were self-employed, independent contractors and acted as gate keepers to the NHS. This led to problems in the provision of health care in the years to come as the English government had little control over the GPs (Sines, Appleby and Raymond, 2001). In the U.K. today, Health visitors, Midwives and District nurses in the community remain an important part of the NHS (Quaille, 2016), however there is no clear definition of Public
Health Nursing in the UK. The term Specialist Community PHN is relatively new in the UK, it was 2004 when it was included in the third part of the register by the National Midwifery Council, (NMC, 2004) and it is used to describe specific nursing specialities, such as infection control nursing and community-focused health visiting. And while all nurses in the UK have a potential public health role, health visiting in particular has attracted the title PHN, however it is clear that no one branch of nursing in the UK can claim the public health title (Quaille, 2016).

2.4.2.2 The US

In the United States, Lilian Wald is credited with coining the name Public Health Nursing. In 1893 in New York City Lillian Wald and Mary Brewster set up a nurses’ home on the lower East Side which was mainly an area of the poor which included immigrants of Irish, Jewish, Chinese and Italian descent. This became known as the Henry Street Settlement House where the visionary work of Lillian Wald evolved. Lillian Wald believed that public health nurses must treat social and economic problems, not simply take care of the sick (Fee and Bu, 2010). Wald put great emphasis on treating the poor with dignity and not blaming the poor for their poverty and disease, in contrast to social commentators of the time (Fee and Bu, 2010). In 1912, the National Organization of Public Health Nurses was formed with Wald as its first president.

The first public health nurse for the U.S. Public Health Service was appointed in 1913. They expanded the nursing service to all nationalities across the city. In these pre-antibiotic years treatment for any of the infectious diseases essentially consisted of nursing care given by the nurse or the family under her instruction (Lusk, Keeling and Lewenson, 2016). In the early part of the 20th century, based on this concept of care, Visiting Nurse Associations began in Buffalo, Boston and Philadelphia. Wald worked closely with another nurse Mary Brewster and believed that public health nurses should be involved with the health of the entire neighbourhood and co-operate and work/collaborate with other agencies to help improve living conditions. Wald was an advocate for the poor and taught local federal agencies and organisations about their needs. (Stanhope and Lancaster, 2000). Essentially, they built effective partnerships with the communities they worked with to improve health. This core principle community participation is still at the heart of public health nursing in the United States. When Wald retired in 1933 the service cared for 100,000 patients. Public Health Nursing in the United
States was founded on the recognition of poverty and the need for public services to be responsive to diverse socioeconomic and cultural groups (Erickson, 1996). In the US, PHNs grew directly from nursing organised by voluntary associations outside of medical supervision resulting in autonomous practice, whereas the UK service grew more in line with medical guidance (Craig and Lindsay, 2000). Presently, in the United States, the term community health nursing is used as an umbrella term to include all nurses outside of institutions, the main distinction between PHNs and community health nurses is that PHNs focus on populations/communities and community health nurses target their services towards individuals and families (Craig and Lindsay, 2000). PHNs in the USA are actively involved in vaccination programmes and communicable disease and surveillance. PHNs monitor the health status in their communities, heart disease is the leading cause of death in the US, thus many PHNs hold blood pressure, diabetes, and cholesterol screening clinics to educate their clients and encourage healthy lifestyles through exercise and good nutrition. The service today is the “visiting nursing service” of New York, one of the biggest home health organizations in the country (Fee and Bu, 2010, p.1206).

2.4.2.3 Canada
Public health nursing in Canada has its roots in the pioneer days, little is known about Canada’s first PHNs, it is assumed that they worked for charitable or religious organisations in many areas of the country (Rutty and O’Sullivan, 2010) Health and social welfare matters were the delegated responsibility of the provinces after the Canadian Confederation in 1867 (Rutty and O’Sullivan, 2010). The first Public Health Act was passed in Ontario in 1884, this Public Health Act became the model for legislation in other provinces across Canada. Dr Young one of the pioneers of public health in British Colombia in his 1928 address to the Canadian Public Health Association said it was like crying in the wilderness, nobody wanted to listen, the public were not concerned with epidemics. It was only post World War One, when one third of the youth of Canada were turned away from military recruitment due to be medically unfit, that the public were in a mood to accept advice (Porr and Dosani, 2010). Provincial health authorities broadened their scope from sanitation to general health protection and advice. Dr Young proposed to start with children’s health and concluded that a logical person to help him would be a trained nurse. Nurses were rare and curative in nature and not trained. MS B Swan Lewis was the first nurse to assist this new public health programme in British Colombia. (Porr and Dosani, 2010). The PHN nursing programme was established in 1919, the first
nursing degree programme in the British Empire. The first PHN course was run at the University of Halifax in February 1920, followed by Universities in Toronto, Western Ontario, British Colombia and Alberta (Rutty and O’Sullivan, 2010). Eunice Henrietta Dyke in 1905 (a trained US state nurse) who was a Toronto-born Canadian employed by the Department of Public Health of the City of Toronto; pioneered the idea of positioning child welfare services as the core of the department’s child health centres (Porr and Desani, 2010). The child’s family became the focus of public health nursing services and PHNs became responsible for families on a district basis. Decentralisation of public health nursing services was ground-breaking and gained recognition rapidly around the world (McKay, 2005). The first PHNs worked in Schools and were supported by the Department of Education who gave grants to local authorities to employ a nurse as well as a teacher (Rutty and O’Sullivan, 2010). Children who were at risk were identified at schools and PHNs often used this information to engage in home visits with vulnerable families. PHNs were influential in reducing high mortality rates among school-aged children by controlling communicable diseases such as Tuberculosis (McKay, 2005).

Between 1911 and 1929, PHNs were employed by local provincial authorities which is still the current practice (CPHA, 2010). Canada has a remarkable good record in Public Health showing an increase of 30 plus years since the 1900’s. Twenty-five of these can be attributed to advances in Public health and the work of PHNs (Porr and Dosani, 2010). According to the standards of Practice (CHNC, 2008), PHNs perform the roles and responsibilities as outlined in the six essential functions of public health (CPHA, 2010):

1. Health protection
2. Health surveillance
3. Population health assessment
4. Disease and injury prevention
5. Health promotion
6. Emergency preparation and response

One of the major differences between Canadian and Irish PHNs (which is state legislated and led by a national registration organisation) is that the Canadian PHNs practice is derived from a combination of organizational, provincial and federal standards for example the PHNs in Manitoba, practice standards are set out by the college of registered nurses of Manitoba and the Canadian Nurse Association’s code of ethics which means that PHN practice can vary from Province to Province and lead to inconsistency and lack of clarity with the role (CNA, 2008; Porr and Desani, 2010).
2.4.3 Ireland.

When discussing the development of PHN, it is important to acknowledge that Ireland was part of the UK till 1922 so they are similarities up to that period. However, it is possible to discern different trajectories both pre and post-Independence. In the early nineteenth century the sick generally were cared for in their own homes by untrained persons. It was late in the century before training schools for district nurses developed (Fealy, 2005). In 1876, Lady Plunkett established the first training school for district nurses in Dublin. The Queen’s Jubilee nurses were also trained in Dublin. They resided in a house in St Stephen’s Green, which served as their home and school. The inscription over their door of the home read “District nurses for the sick poor” (Armstrong, 2000, p.126). In Ireland, the Famine of 1845-1850 had greatly reduced the population, the total population dropped by 25 per cent or two million people; one million are estimated to have died the other million emigrated to the America, Canada, Scotland, Wales and England (Trueman, 2015). At the same time, the urban population increased due to movement from the rural areas which increased the number of people living in extreme poverty (Fealy, 2005).

Nursing in the community was first legalised with the introduction of the Poor Relief Act in 1851. This Act compelled local authorities to appoint midwives to assist medical officers in the provision of district midwifery services. By 1905 there were 605 of them in post. Several voluntary organisations provided a district nursing service such as The Irish Sisters of Charity, Mercy Sisters, Little Sisters of the Poor, the Queen’s Institute 1887, known as the Jubilee nurses, and the Lady Dudley Nursing Scheme which augmented the public service provision (DOH, 1997). The nurses employed by the

5 Lady Plunkett Countess of Fingall was born in Moycullen, a daughter of George Edmond Burke of Danesfield and became an activist in Irish industrial, charitable and cultural groups.
6 A Queen’s Jubilee nurse is a nurse trained and employed by the Queen’s Jubilee Institute.
7 St Stephens green Location: Centre of Dublin city, at the top of Grafton Street, where the nurses became known as the nurses out of the Green.
8 Queen Victoria’s Institute for Nurses employed district nurses and was funded by the public subscriptions raised to honour the golden jubilee of Victoria’s reign in 1897.
9 Lady Dudley Nursing Scheme: In 1903 lady Dudley the wife of the Lord Lieutenant of Ireland plan was to establish trained and committed nurses, who would live in specially built houses within the community and be on call for the sick. Using her own persuasive personality, and her husband’s considerable influence, she persuaded the government, and every person with money to spare, to support her project. It was an outstanding success. The Lady Dudley Nurses eventually spread throughout the west from Donegal to West cork serving people in the poorest areas of Ireland.
associations provided services for the sick poor in the most deprived areas in the country with the Jubilee nurses serving the East of the country and the Lady Dudley nurses covering the western areas. These nurses and midwives became very well-known and respected in their areas. In the main, referrals to the nursing service were received from hospitals, general practitioners, Jubilee committees\textsuperscript{10} and pharmacists. These services were provided during a time of great poverty, people's homes were overcrowded, 36\% were one room tenement (CSO, 2014). Water and sanitation facilities were limited. According to the statistics of 1916 about one in eight deaths was due to bronchitis, pneumonia and tuberculosis (CSO, 2014). Chronic illnesses and patients with communicable diseases such as cholera and tuberculosis took much of their time (Scanlan, 1991). The notification of Births Act in 1915, obliged health authorities to employ nurses to visit mothers and all children under five to detect and treat any illnesses and to promote health. In 1916, the infant mortality rate was, for every 1,000 live births, 81 of those died before they reached twelve months (CSO, 2014). The highest rate was in Dublin City at 153.5 per 1,000 births. Together the Jubilee nurses and the Lady Dudley nurses were enmeshed in developing child welfare clinics to monitor the child's development with the Jubilee nurses working mainly in the east and in the midland regions whilst the lady Dudley nurses worked in the south and west of the country. In 1919 the Medical Treatment of Children Act legislated for a school nursing service free to all children, however it was 1924 (post State Independence) when the school nurse service was introduced, the examination of each child included eye examinations, dental, throat, chest and physical measurements such as height and weight (Armstrong, 2000). Ireland has had a willingness to share its responsibility of its people with non-state organisations mainly the Catholic Church; this was formally started under British rule in the nineteenth century when the welfare of its Irish Catholic citizens was largely given over to the Catholic Church (Inglis, 1998). The Catholic Church remained a force on health, social and education matters until right up to the latter part of the century (Moran, 2009).

Immunisations programmes were gradually introduced by community doctors supported by the local nurse which helped to reduce the incidence of infectious disease which in turn reduced mortality. In 1939 there were 47,061 cases of Diphtheria with deaths of

\textsuperscript{10}A Jubilee committee was a local district nursing association affiliated to Queen Victoria's Jubilee Institute for Nurses which employed district nurses and was funded by the public subscriptions raised to honour the golden jubilee of Victoria's reign in 1897
2,133, by 1970 there were 1-2 cases of Diphtheria with no deaths recorded (HSE, 2016). By the 1940s and into the 1950s many of the infectious diseases were brought under control and other serious diseases such as cerebrospinal fever and critical pneumonia were effectively treated due to the evolution of new antibiotics. Tuberculosis was still evident, in 1952 the number of cases of Tuberculosis recorded was 48,093 with deaths of 10,590, compared to in 1996 there was 5,589 cases with only deaths of 420 (HSE, 2016). Nurses visited their homes giving injections of streptomycin and ensuring that patients took their oral medications in a bid to reduce and prevent its spread (Armstrong, 2000). In many cases the nurse had a dual role working as a district nurse and as the appointed midwife in the area, these nurses became known as Public Health Nurses, health authorities employed relief nurses to work with PHNs (Robins, 2000). The relief nurse often covered while the public health nurse was on leave (Armstrong, 2000). Following a long campaign by many different interests both of nursing and medical stature, of voluntary and state organisations, the Nurses Bill of 1950 was passed to improve education and training and registration of all nurses (Fealy, 2006). A registration board was set up by the Department of Health, An Bord Altranais, which is now known as the Nursing and Midwifery Board of Ireland.

2.4 3.1 Registration and Education of PHNs in Ireland

An Bord Altranais was established in 1951 by the Minister of Health to regulate education, registration, and other matters relating to nursing (Scanlan, 1991). State registration placed nurses in Ireland on a professional footing (Fealy, 2006). In the 1956 Health Act, all nursing services in the community were to form one public health nursing service and most of the nurses in the community became registered PHNs in the 1960s. Educational programmes were developed in the early 1960s by An Bord Altranais and the various health boards. These programmes varied in length from two months to six months. The Department of Health issued a report in 1966 (circular 27/66) whereby all educational programmes for nursing in the district would have a distinct public health focus, where nurses would begin to focus and identify the needs of the community where they worked. These nurses would have a midwifery qualification. On completion of these programmes the nurse could register with An Bord Altranais as a Public Health Nurse.
The health boards\textsuperscript{11} also facilitated other nurses in the community the opportunity to complete the education programme. In 1972 the duration of the course was extended to nine months and in 1981 to twelve months, as it was recognised the wealth of knowledge that nurses required to work in the community. An Bord Altranais continued to facilitate this programme until its move to a third level college University College Dublin in 1986. This move was prompted by superintendent public health nurses seeking to gain international recognition for this qualification (Armstrong, 2000) and "the need of society for the service of adequately educated nurses" (Scanlan, 1991, p.297). University College Cork (UCC) began to offer the course in 1994, nurses now graduating would have a diploma in public health nursing. For entry into the programme nurses would have to have a prior dual qualification as a general nurse and as a midwife. In 2004 this requisite of dual qualification was changed following a recommendation from the Commission of Nursing 1998, whereby nurses who were not registered midwives could apply to be a PHN. Nurses did however still require two years 'clinical experience before entry (DOH, Circular 41/2000). This amendment was reflected in the removal of the provision of domiciliary midwifery care in the job description for a PHN (DOH, 2000). A Maternal and Child health module was introduced and mandatory for those without midwifery registration (Nursing and midwifery Board of Ireland, 2015). The removal of the requisite of Midwifery could be due to the fact homebirths in the community had fallen since the mid 1960's with hospital births rising due to improvements in maternal, perinatal and obstetric care (Fealy, 2006), hospital births, the medical and consultant-led model remains dominant in Ireland to date.

The generalist role and the broad diversity of client groups, which the PHN cares for, are reflected in the rationale and curriculum of the education programme (Hanafin, 1997; NMBI, 2015a). The course continues to be of 12 months' duration, with University College Galway joining in 2006. The program aims to prepare nurses, for working in the community setting as a Public Health Nurse, addressing the healthcare needs of the community as a client. A key part of this program is the development of nursing expertise in targeting public health needs and delivering healthcare services from a population health perspective (NMBI, 2017a). Site visits of university and college departments and their partner hospitals and health services are conducted by the Nursing and Midwifery

\textsuperscript{11} The Health Board system was created from the Health Act in 1970 by the DOH. This system was initially created with eight health boards increasing to eleven in 1999, each of which were prescribed a functional area in which they operated. and was dissolved in January 2005.
Board of Ireland (NMBI) in compliance with the Nurses’ and Midwives Act of 2011 and to ensure high standards of nursing and midwifery education and practice (NMBI, 2017).

2.5 Development of Public Health Nursing Services in Ireland

The continuing developments in the education and training of PHNs greatly enhanced the growth of the Public Health nursing service. To further advance this service, the policy framework for the PHN Service was first presented by the Department of Health in Circular 27/66, entitled District Nursing Service (DOH, 1966). This Circular set out several client groups and duties to be carried out by RPHNs, which will be discussed in the following section.

2.5.1 Public Health Nursing Policy Framework, Department of Health - Circular 27/66

The Ministerial Circular 27/66 in 1966 outlines the broad role of the public health nurse. The aim of the service was to, “make available a comprehensive universal community nursing service for all groups in the population” (Department of Health, 1966, p. 3). The Circular also recommended that a Superintendent should be appointed to an area where ten or more public health nurses were working. To date this circular, has not been superseded despite many social, health and demographic changes. Chavasse (1998) twenty years ago argued that PHNs have been largely ignored by the policy makers and planners and this circular 27/66 is obsolete however it still is the only statutory instrument outlining the specific functions of the PHN. O’Dowd (2013) argues that this current model of PHN nursing established in 1966 does not address the child health programme. It is the core strategy relating to the role of the public health nurse, (DOH, 1975; Burke, 1986; Government of Ireland, 1998; National Directors of Public Health Nursing and Shannon, 2014). The PHN focuses “on a district or area meeting the curative and preventive nursing needs of the population” (Department of Health and Children, 2000 p.4). The public health nurse’s role is that of a generalist in the community, involving all client groups (Hanafin, 1997). A ratio of one public health nurse to every 4,000 populations was adopted as a guideline but this may alter from one geographical area to another. Their duties at the time are outlined by Scanlan, (1991, p.158) as to:

- Undertake home nursing and domiciliary midwifery
- Attend clinics and dispensaries
- Assist in school medical examinations,
• Assist medical officers of local authorities in the provision of services to eligible people
• Include home visits to advise on health matters to the aged, the sick, children and infants and to the mentally handicapped.
• Child welfare
• Prevention of diseases
• Clerical duties keep records and supply reports as required to local authorities
• Home visits to psychiatric patients
• Preventative services of child health/development and surveillance of the well elderly was introduced.

From 1966 to 2000 the health service encompassed significant changes particularly in general practice, in services for children and the elderly and in the organisation of hospital services (McDermott, 1994). The role of the PHN has undergone considerable change in the last forty years in response to demographic, social and epidemiological changes in community health needs, and has outstripped the expectations of the 1966 circular which "greatly underestimated the diversity and range of activities of [the PHN’s] multifaceted role" (Begley et al, 2004, p.3).

Four reviews took place in 1975, 1986, 1994 and 1997 by the Department of Health to re-examine, the workload and the role of the PHN which have led to developments such as the establishment of the post of Nurse Adviser Community Nursing Services in the Department of Health in 1981 and the establishment of the Institute of Public Health Nursing in 1985 (DOH, 1997; National Directors of Public Health Nursing and Shannon, 2014). The Commission of Nursing in 1998, (GOI, 1998) on the basis of the reviews, listed above, recommended a new vision for public health nursing in Ireland which is outlined in the Department of Health Circular 41/2000 in the following paragraph.

2.5.2 Department of Health and Children Circular 41/2000

The Department of Health and Children issued new job descriptions/profiles which reflected the recommendations contained in the Commission on Nursing report (Government of Ireland, 1998; Department of Health and Children, 2000). This was the first time an explicit Job description for public health nurses and registered general nurses working in the community services was presented (Begley et al, 2004). Superintendent and Senior Public Health Nurses titles were changed to Director of Public Health Nursing
and Assistant Public Health Nursing following a recommendation by the Commission of Nursing (GOI, 1998). Circular 41/2000 provided PHNs with a broad outline of their role as a key provider within the context of the new multidisciplinary primary care teams. From 2000 onwards PHNs were not expected to attend home-births. Registered nurses' responsibilities were also outlined as to liaise closely and support the public health nursing service, to maintain a high standard of nursing care as part of the community nursing team (Department of Health and Children, 41/2000).

Having explored the relevant policy framework to Public Health Nursing, there is a strong legislative basis for public health nursing in Ireland which will now be discussed.

2.6 Legislation in the Context of Public Health Nursing.

The legislation governing the existing Public Health Nursing service date back to the Notification of Births Act 1907 and the extension of this Act in 1915.

2.6.1 The Health Act 1970

Fundamental changes in the organisation of the health services came with the Health Act of 1970. The Health Board structures were established and obligated to provide certain community-based services at regional level (DOH, 1997). Families were means-tested to see if they were entitled to a free service and they now could choose which medical practitioner they attended. Doctors moved away from the local dispensary/health centre to their own private rooms. This meant that the PHNs and the doctors were less likely to work as closely and that the PHN who was geographically based would now have many different doctors looking after her clientele rather than one (Armstrong, 2000). The current Public Health Nursing service is still legislated under 4 sections of this Health Act;- Section 60 deals with the provision of a home nursing service, all medical card holders and children are eligible for a service which is free at the point of delivery, section 62 and 63 cover health services for midwifery and medical care of mothers and section 66 enacts care for infants and children of pre-school and of primary school (National Directors of Public Health Nursing and Shannon, 2014).

2.6.2 Child Care Acts 1991 and 2015

The role of the PHN service in safeguarding and protecting the health and well-being of Children is also provided for in legislation in the Child Care Act (GOI, 1991) and the
Children’s First Act (GOI, 2015). These Acts mandates timely, co-ordinated and apposite responses to child welfare and child Protection. The PHN service provides an extensive range of services within the HSE, it includes post-natal visits and developmental screening up to six years of age. Immunisations programmes are provided as part of the school health service. PHNS are involved in the assessment of need and the provision of services to children with disabilities. It is mandatory that every mother and baby will be seen by the PHN within 48 hours of discharge from a maternity hospital (DOH, 1997; NDPHN and Shannon, 2014). The PHN’s role has changed from a supervisory, home visiting one to that of educating and empowering parents to promote their own children’s health (Armstrong, 2000). O’Dowd (2013) states that 47% of children referred to the child care system are referred by the PHN.

2.7 The Influence of the WHO on Public Health Care provision and its subsequent influence on public health nursing

The World Health Organisation (WHO) has driven the model of primary health care as the means of achieving better health for all by tackling health inequalities in all countries. The WHO (2017) has identified five key elements to achieving that goal:

- reducing exclusion and social disparities in health (universal coverage reforms);
- organizing health services around people’s needs and expectations (service delivery reforms);
- integrating health into all sectors (public policy reforms);
- pursuing collaborative models of policy dialogue (leadership reforms);
- increasing stakeholder participation.

The model of primary healthcare began in 1978 with the Alma-Ata declaration which will now be summarised in the following section.
2.7.1 The World Health Organization: Alma-Ata declaration 1978

The Alma-Ata Conference is described as having:

...mobilized a Primary Health Care movement of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to tackle the politically, socially and economically unacceptable health inequalities in all countries (WHO, 2008 p. xii).

The WHO Alma-Ata declaration of 1978, Health for All, promoted health for the entire population through primary care delivery in their own communities. Promotion of health and prevention of ill-health was to take prominence in the provision of community care. Several governments worldwide have produced strategies/policies to ensure the provision of primary care becomes a reality, e.g. Saving lives-Our Healthier Nation (DOH, UK. 1999) which proposed to save lives, promote healthier living and reduce inequality in health; Who will keep the Public Healthy (Institute of Medicines, US, 2003), the report recommendations include establishing partnerships between schools of public health and other academic disciplines, local and state health departments and community organizations; adding public health training to medical and nursing school curricula; and increasing federal funding for public health research. Following on from the Alma-Ata declaration of 1978, was the Munich Declaration of 2000 which will now be explored.

2.7.2 The Munich Declaration WHO 2000

The WHO stressed the importance of nurses and midwives as a “force for health” in tackling our public health challenges of our time (WHO, 2000, p.1). These challenges are derived from a social model of public health that appreciates the influence of our behaviour, our environment, and our culture on our well-being (Clarke, 2004). The report states that nurses and midwives play a pivotal part in confronting these. The Ministers of Health of the European Union of the WHO stated their commitment to enhance the role of nurses and midwives in public health and the need to acknowledge the historical, political and cultural factors that facilitate health and those that aggravate health. (Clarke, 2004). The WHO having recognised the importance of the healthcare workforce, it stressed the important part all society has in improving health which will now be discussed.
The latest WHO policy, Health 2020 aims to reduce health inequalities and ensure people-centred health systems which are universal and equitable to all (WHO, 2013). Health 2020 has two common objectives that to improve health for all and reduce the health divide and the need to strengthen leadership and participatory governance for health (WHO, 2013, p.11). It proposes that health and well-being are the responsibility of the whole of society as well as the government. It actively encourages public participation in policy-making. Historically, PHNs in Ireland have been slow to get involved in policy making (Clarke, 2004) and need to get political. Health is a major societal resource and asset. Poor health wastes and drains resources across all sectors and enabling people to take control over their health strengthens individuals and improves lives (WHO, 2013). PHNs are in a key position to assess the health needs of the population and be part of designing services to promote good mental and physical health (Hanafin, Houston and Cowley, 2002; NDPHN and Shannon, 2014). The aim of Health 2020 is beneficial to the work of particularly PHNs whose focus is primarily health protection and disease prevention. The WHO (2015a) emphasised that nurses and midwives should use every opportunity to address health inequalities and to positively influence health outcomes throughout the life-span. Nurses and midwives are considered essential in fostering client partnerships and empowering individuals, families and communities, principally in primary care settings (WHO, 2015a). This is underpinned by identifying that nurses and midwives are cost effective and comprehensive primary care services can reduce hospitalisations and prevent negative health outcomes through, for example, identifying medicine misuse such as poly-pharmacy. In Ireland, the first strategy concerned with the shift to primary care was “Shaping a Healthier Future”, published by the DOH in 1994.

Shaping a Healthier Future 1994

The key concepts in this strategy were health gain and social gain and are described as a strategy to re-orientate our healthcare system with great emphasis on primary care (McDermott, 1994). The three key principles that underpin the strategy are equity, quality of service and accountability (DOH, 1994). The strategy stated that the role of the public health nurse needed to be strengthened in supporting older people and their careers at home as the number of persons aged over 65 is expected to grow by 40% in the next twenty-five years and the number of persons aged over 85, where the likelihood of
dependency is greatest, is expected to grow by 60% (DOH, 1994). Also, additional resources and greater priority needed to be given to information gathering and monitoring function of the PHN to assist local service planning (McDermott, 1994). The Declaration by the WHO has had a huge impact on the development of Public Health Nursing worldwide, whereby a lot of the responsibility of delivering primary health care fell on their shoulders. (Leahy-Warren, 1998). The WHO reiterated the crucial role that nurses, and midwives play in promoting health in Munich 2000

2.7.5 Primary Care: A new direction

Within this context the Irish Government, the Department of Health set out a detailed plan to incorporate primary care into the health service (DOHC, 2001b) which will now be outlined. This strategy envisaged that having primary care as the central focus that it would lead to better health outcomes and lead to greater cost effectiveness in community care (DOHC, 2001b). Primary care would improve access to services, increase coordination between primary care health providers such as between general practitioners, physiotherapists, dieticians and community nursing teams by assimilating primary care teams (PCTs). One of the key targets was that this model of care would deliver 90% of health care need to the Irish population (DOHC, 2001b; HSE, 2013). Much of the focus on this reform is on GPs. In contrast to the previous strategy (Shaping a healthier future, 1994) there is no reference to public health nurses, the terminology used is nurse or midwife (DOHC, 2001; NDPHN and Shannon, 2014). Bryar et al in 2012 stated that it is nurses who provide 90% of all healthcare services. Primary care in Ireland has undergone a substantial transformation since the publication of the strategy in 2001. Primary care services were fragmented and did not capitalise the shared potential of community healthcare professionals (Ombudsman, 2008). As part of this transformation, ten pilot primary care teams (PCTs) were established in 2003, which provided a practical demonstration and test of the primary care model in practice. The first primary care centre established was in Dingle, Co. Kerry. Core members of the team were the GP, practice nurse, PHN, community registered general nurse, community mental health nurse, physiotherapist, occupational therapist, social worker and Home Help Organiser. Additional professionals such as dieticians, podiatrists and speech and language therapists were also available if referral was needed. The PCT’s aim is to deliver person centred medical and non-medical care for both health and social needs at local level (Burke and
The main aim of this reform is to achieve a more balanced service by treating most patients within the primary care setting.

However, the implementation of the Primary Care Strategy (DOHC, 2001a) over the past decade has been described as 'very challenging'. There has been a lot of success but there have also been a lot of questions around how well the teams are functioning and there are a lot of challenges to do with GP participation in the team. The Strategy predicted between 400-600 PCTs by 2011. According to the Auditory General's office (2011), 319 PCTs have been set and are functioning the most recent HSE (2014) data states that there were 485 teams at the end of 2014. The realisation of the number of PCTs has been slow there has been substantial debate around what constitutes a fully functioning PCT (O'Sullivan, Cullen and McFarlane, 2015.) In May 2012, the ICGP chief executive suggested that only a third of PCTs were working effectively, a third were partly functioning, and another third existed in name only. In a report outlining GP perspectives on PCTs, the ICGP endorsed the 'theoretical basis for PCTs', but also outlined a very wide range of barriers to GP involvement under a few different headings: management; meeting structure; disintegration of services (House of the Oireachtas report, 2014). This is a similar finding to a survey carried out with GPs, where only 36% were functioning as part of a PCT team (Darker, et al, 2011). The limited evidence suggests that PCT working is not routine and it is still rare for GPs to work alongside other health professionals to provide an integrated primary care system (O'Sullivan, Cullen and McFarlane, 2015).

Specific challenges for PHNs involved and being part of a PCT is that their service is immediate for their clients like the GPs, there is no waiting list, however other members of the PCT for example; occupational therapists and physiotherapists, their specific caseload numbers are capped, resulting in long waiting lists for their specialist services (O'Neill and O'Keefe 2003). The consequence for the PHNs is that they are left to continue supporting this population group within PCTs, while other services are unable to provide specialist services (Nic Philibin et al 2010; Giltenane, Kelly and Dowling, 2015).

This in turn creates challenges for the PHN in delivering a nursing service as part of the PCT (Nic Philibin et al 2010). In a research study (Tierney et al, 2016) on the implementation of PCTs results showed that GPs viewed interdisciplinary working as important but were more negative about its effectiveness than other primary care providers. Payments to attend meetings were considered an important factor by GPs but not by nurses and clinical therapist (Tierney et.al, 2016). There is evidence of significant
problems that disrupt team formation and functioning that warrants more comprehensive research (O'Sullivan, Cullen and MacFarlane, 2015). Giltenane, Kelly and Dowling (2015) in their research on PHNs experience of PCTs found two main concerns firstly that the PHNs' role had expanded without increased resources and secondly the increased volume of paperwork involved when working as a PCT member. Their study did find that face to face meetings did help build rapport, increase trust and improve interprofessional communication (Giltenane, Kelly and Dowling, 2015). However, similar to other studies, there was room for substantial improvement in interprofessional collaboration and communication (Giltenane, Kelly and Dowling, 2015; Tierney, et.al, 2016). PHNs have an important function in profiling and identifying the health needs of local communities alongside their colleagues in the PCTs (DOH, 2013a). A population health information tool has been developed and the implementation of this digitally country wide would provide information on population health needs for many services including the PHN service (ONMSD, 2011; McDonald, 2013). This to date has not been implemented.

The national strategy (DOHC, 2001b) on primary care specifically calls for more participation between the state and the voluntary and community sector. Had this strategy been fully embraced this would empower and augment the advocacy role of PHNs in ensuring that issues which influence health are acknowledged (Cawley and Mannix McNamara, 2011). It is evident that PHNs have a critical part to play in supporting the implementation of these initiatives to develop and enhance PCTs (NDPHN and Shannon, 2014). PHNs are in a unique position to identify problems arising, refer and to follow-up as they are the only nurses who visit the home, therefore making a significant contribution to the PCTs (O'Dwyer, 2012). The core aim of primary care is to achieve a more balanced health service by ensuring the clear majority who require the care are managed within the primary care setting (HSE, 2013). Consequently, the PHN service contribution is critical to its' success (NDPHN and Shannon, 2014). Having discussed the influence of the WHO on the role of the PHN, the following section will now look at the current role of the PHN

2.8 Current role of the Public Health Nurse

Whilst examining the literature, it is important to state that the role of the Irish PHN is unique, because of the preventive and curative role it has across the lifespan and it is difficult to draw international comparisons. Community nurses have many titles and the role of Irish PHNs incorporates activities undertaken by a variety of health professionals
in other countries (Brady et al, 2007). See Appendix C for further details of international roles.

PHNs are the largest and longest established nursing group in the community (Leahy-Warren, 1998; INMO, 2013). The current number stands at 1,483 (HSE, 2018a). Due to a shortage of PHNs in the 1980’s community registered general nurses (CRGN) were introduced into the nursing service to provide clinical general nursing care. The CRGN works with the PHN, mainly providing clinical care to the older population in a role that has been developed in an ‘ad hoc’ manner without any clear plan (Hanafin and Cowley, 2003; Giltonane, Kelly and Dowling, 2015). Home helps, and care assistants were also introduced and work closely with the Public Health Nursing team to provide practical assistance to families in their home (Burke and O’Neill, 2010). Both play an essential role in maintaining people in their own homes (NDPHN and Shannon, 2014).

The current role/job description of the PHN is outlined in Circular 41/2000(DOH, 2000) based on the recommendations contained in the Commission of Nursing report (GOI, 1998). The PHN focuses “on a district or area meeting the curative and preventative nursing needs of the population within the area” (DOHC, 2000, p.4). The PHN is to provide a broad-based integrated prevention, education and health promotion service and to act as co-ordinator in the delivery of a range of services in the community. The PHN in exercising his/her professional autonomy is expected to maintain a high standard of nursing care, to share responsibility with the community nursing team for the management of nursing care and the patients’ environment and to maintain a high standard of professional and ethical responsibility (DOHC, 2000).

PHNs work in a specific geographical area, based in local health centres. PHNs are the only nurses universally available and work with a multiplicity of client groups (ICHN, 2013a; NDPHN and Shannon, 2014). These include all ages who require a domiciliary clinical nursing service, infants and children, people with mental health issues, the anticipatory and nursing care of older people, people with physical and intellectual disabilities and those from ethnic minorities including the traveller community, Roma communities, asylum seekers and the refugee population (Hanafin and Cowley 2005; INMO, 2013). The HSE description of the PHN is somewhat limited, concentrating more on two population groups the elderly and the young; works with adults to provide home and clinical nursing care to persons over 65 years who have a medical card. Services include post hospital care, dressings, injections, referral to respite and day care and
assessment for nursing home subvention, home support, nursing aids and appliances (HSE, 2017a). With children, the PHN will visit you within 48 hours of discharge following the birth of your baby. They will continue to visit during the pre-school period. They will provide advice and guidance on diet, breastfeeding, bottle-feeding, weaning, immunisations and child safety. The school nurse visits all schools and carries out vision and hearing screening for all primary school going children (HSE, 2017a). In practice, the focus of the PHN service is on children and older people (Hanafin, 1997; Chavasse, 1998; Leahy-Warren, 2012; ICHN, 2015). The importance of the PHN service for the elderly population was demonstrated by McNamara et al (2013) who identified that one in four older people received a PHN visit in a 12-month. A number of Irish studies have looked at the different aspects of the role of the PHN in Ireland. Each one of these studies provides valuable insight and helps develop our understanding of the nuanced differences of the different aspects of the role. For example, a small-scale qualitative study (n=9) carried out by Giltenane et al (2015) explored the role of the PHN within the context of a primary care team. This albeit, small scale study illustrated the issues associated with PCTs as discussed earlier in section 2.6. Another important finding of this study is that since the introduction of the PCTs the PHNs’ health promotion role has been pushed aside due to the management of clients who are acutely ill. This is similar to the findings of the INMO (2013) an online survey of (n= 632) study which stated the PHNs role was becoming more like the fire brigade service responding to emergencies despite not being an emergency service. A total of 70% (n=321) of respondents felt that they do not always have enough time to deliver the required level of care to meet patient/client needs, and 87% (n=410) stated that their workload had increased in the past year (INMO, 2013, p.18)

2.8.1 Current relevant policy that is influencing the role of the PHN

Public Health Nursing is impacted by the health service reform programme, a determined policy commitment to health and well-being and the legislative, organisational and structural objectives related to child and family care (National Directors of Public Health Nursing and Shannon 2014). Furthermore, professional activities are prescribed by the nursing regulatory authority (NMBI, 2016). Practicing nurses and midwives in Ireland must be registered with the Nursing and Midwifery Board of Ireland and practice under the Nurses and Midwives Act (GOI, 2011). All PHNs must practice in accordance within the specific policy guidelines such as recording clinical practice (NMBI, 2002),
medication management (NMBI, 2007), the Code of Conduct and Ethics (NMBI, 2014) and the Scope of Nursing and Midwifery Practice Framework (NMBI, 2015b). Given the breadth of the PHN service, its work is influenced by many policies. Political policy dominates how nurses practice (Baggott, 2004). Three main policy areas which has influenced the PHN service, (a) Health service reform programme outlined in a strategic framework document called Future Health (DOHC, 2012) (b) The health strategy, Healthy Ireland focusing on the health and well-being of the population (DOH, 2013a) and (c) re-organisation of services to children and families. In the following sections a brief outline of each reform will be given and its contribution of the PHN service will be identified.

2.8.2 Future Health

The key reforms outlined in this document are to improve, the quality of care delivered, access to all services and improve cost-effectiveness (DOH, 2012). An important element of this programme is clinical governance both at individual and at an organisational level. Patient safety has become a central focus of health service delivery (HSE, 2009, HIQA, 2012a). PHNs will need support for clinical governance in community settings to ensure safe and efficient clinical practice (NDPHN and Shannon, 2014). The PHN service is actively engaged in care provision for the elderly, in assessments, screening, clinical nursing care, social care support, day care support, respite care, referral to multidisciplinary team members and acute care if warranted. The maintenance of elderly patients with high dependency needs has led to an increase in demand for clinical nursing and home supports from the PHN service. An increase in Home care packages have increased from 8,000 on 2008 to 10,870 in 2012 (HSE, 2013). The Tilda Report (2016) a report based on the utilisation of the PHN service by older adults aged 50 years or older found that; 6.6% of adults in this age group and 33.7% of those aged 85 years and older utilised the service. The report found of those who self-rate their health as poor 24.3% and 38.5% of those with a difficulty maintaining their independence used the PHN service. Satisfaction rates with the PHN service were good (90%), with some adults expressing discontent with inadequate provision, 7.1% identified insufficiency in service as an issue, while 1.3% identified the service as hard to access. No substantial difference was found in the utilisation of the PHN service between rural and urban location (Murphy, 2015). The findings of the Tilda Report have implications for the HSE, the government who form the policies and for the PHNs in the context of an ageing population. The high
utilisation rate of the PHN service by the older population because of increased dependency in this report has serious implications for the PHN service with the expected increase in this age group in the future (Murphy, 2015).

PHNs, with the GPs\textsuperscript{12}, are the main providers of care in the community to patients with chronic illness, leading to increased demand and access to primary care services. Approximately 65\% of people aged 65 years and over currently have two or more chronic medical conditions and the prevalence of age-related disease continues to show signs of increase (HSE, 2018b). The reform programme looks at developing models of shared care which will set out clinical protocols and guidelines for use in primary care, for those with chronic illness, which will impact on the PHN service especially those patients who are housebound (HSE, 2013). Currently, in practice, one example of shared care is joint-visiting and liaising with the palliative care nurses. Some patients with chronic illness will need general palliative care at the end of life, PHNs together with the GPs and the palliative care team help these patients to be maintained with dignity in their own homes, latest statistics show twenty six percent of all deaths occur at home (Murray, McLoughlin and Foley, 2013). The high mortality rate in the patients that the PHN service visit (10.8\% to 1.9\% of non-users) points to a service with a significant role in end of life care in the community (Murphy, 2015). Many of these will not receive the services of the specialist palliative care teams as they may not fit the referral criteria for palliative care. However, according to the National Cancer Register (2015) the incidence of Cancer is set to double with 1 in 2 of the general population likely to be diagnosed with cancer by 2020. These figures highlight the importance of a standardised palliative care programme for primary care that would guide all community nurses in their clinical practice (NDPHN and Shannon, 2014).

In 2016, the UN Committee on the Rights of the Child recommended that Ireland adopt a right, based approach to disability (UNCRC, 2016), a comprehensive inclusive plan for these children needs to be implemented by the HSE that PHNs work closely with all children and adults with a disability. PHNs provide mainly a supportive role, to families with a disabled child and provide clinical nursing care and social supports to adults with a disability. The PHN is often the first clinician to refer a child with an intellectual disability to the early intervention services; this is done through the screening and child

\textsuperscript{12} GPs are general practitioner doctors based in GP surgeries in the community.
health development checks. The number of children with life-limiting conditions being maintained at home is increasing (O'Dowd, 2013), and the number of paediatric Home Care Packages have increased from 474 in 2016 to 514 in 2017 (HSE, 2017). Many parents need nurses working in the home to provide nursing care to their children as they would not be able to provide this care themselves on a 24-hour basis. The PHN in the area and the Director of Public Health Nurse liaise with the hospital multidisciplinary team and sanction these specific nursing hours before the child’s discharge. The PHN acts as the co-ordinator of care, liaises with the hospital team and nurses from the non-statutory organisations such as the Jack and Jill foundation. Another area of policy reform which is influencing the role of the PHN is outlined in the health strategy Healthy Ireland (DOH, 2013a).

2.8.3 Health and Well-being

This Healthy Ireland strategy (DOH, 2013a) reform focuses on the health and well-being of the population. It states that the health and well-being of individuals and of the population as a whole is Ireland’s most valuable resource (DOH, 2013a). This understanding of health is very similar to the PHN service philosophy (NDPHN and Shannon, 2014) where the focus is on health promotion and disease prevention. The PHN are the only health professionals who visit the home and are in a unique position to raise awareness and address health issues (Leahy-Warren et al, 2012; Hanafin, 2013b; NDPHN and Shannon, 2014). The PHN service sees individuals at all aspects of the life-cycle, from the cradle to the grave is a phrase often used to describe the service. This enables the PHN service to take account of the broader determinants of health and the lifestyle choices individuals make to promote protective factors at every stage of the lifecycle (DOH, 2013a; NDPHN and Shannon, 2014).

The Irish Government, as part of Budget 2014 provided all children less than 6 years of age with access to free GP care which is an estimated number of 420,000 children. This is the first phase of a move towards the establishment of a universal GP service for the entire population, free at the point of contact allowing all families equal access with any concerns regarding their children’s health to their GP (DOH, 2017). All families have universal access to the PHN service. The PHN service practice is informed by the Best
Health for Children 2005 document and the Children First guidelines 2011\textsuperscript{13}, which guides best practice. An emphasis is placed on PHNs to work in partnership with parents and families to achieve good health outcomes through regular child development screening (Denyer, 2005). In 2011, 83.6% of all new-born infants received a PHN visit within 48hrs of hospital discharge (DCYA, 2012). The latest figures available September 2017 show that 98.8% of all new-born babies were seen within 72 hours of discharge, and in CHO 4 (research area) the figure was higher at 99.8% (HSE, 2017b). Williams et al. (2010), in their study found that on average all new-borns received three PHN visits in the first nine months. It is acknowledged that there are substantial benefits from home visiting (Hjalmhult and Lomberg, 2012). In the Early Years strategy (DCYA, 2013), the importance of the PHN service is acknowledged and states it is an excellent preventative system. The PHN service also runs breastfeeding support groups, well baby clinics and parenting classes all to promote the health of the infant and their families. All first-time mothers are referred to the community mothers’ programme who visit the homes and activities are all health promotion lead and adopt a philosophy of empowerment (Molloy, 2010).

The HSE designates the school health service to Area Medical Officers and PHNs. The health and well-being of school children is at the centre of many reports (Denyer, 2005). PHNs provide a school health screening and immunisation programme to all primary children. The immunisation programme is carried forward to post primary. The primary immunisation programme which is actively endorsed by the PHN service has an uptake nationally of over 90% (HSE, 2016a). There is disparity in the provision of the School Service with some areas (22%) having a designated School PHN and other areas depending on the local PHN service (Brady, Lynott and O’Dowd, 2013).

As well as children, PHNs also have an important part to play in promotion of better health in the elderly. The service centres on needs assessments, falls risk, nutrition, promotion of independence, continence promotion and in the prevention of social isolation. Referrals to other members of the PCT are common such as to dieticians and physiotherapists. Referrals to active retirement and day centres help to broaden their social circle and prevent loneliness. The PHN service is the main source of referrals for elder abuse within the HSE (HSE, 2012). Health promotion is a key part of the PHN

\textsuperscript{13} Children First Guidelines is the national guidance document for the protection and welfare of children. Its aim to promote the safety and well-being of children.
service and many problems arising in the older population can be a result of unhealthy lifestyle choices at a younger age (NDPHN and Shannon, 2014). The third area of policy reform relates to the reshaping of health services for children and families.

2.8.4 Children and Families

In 2011, the Department of Children and Youth Affairs was created to transform health services for children and families. Its reform has been guided by many reports, documents and policies such as the UN Convention of the Child (UN, 1989), The Ryan Report (OMCYA, 2009) and Children First: National Guidance for the Protection and Welfare of Children (DCYA, 2011a). It produced the Strategy Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People (DCYA, 2014) which identifies a blueprint for service principles for working with children and families. In January 2014 Tulsa, a new Child and Family Agency was created.

2.8.4.1 Tusla, Child and Family Agency

For the first time in the history of the Irish state there is an agency dedicated to Child Protection and Family Support, Tusla. Its’ services will focus on prevention of problems, identifying problems earlier and provide additional specialist resources to families in specific cases. The PHN service is described as vital to the needs of vulnerable families (Taskforce on the Child and Family Support Agency, 2012). The Taskforce (2012) recommended that Tusla should directly employ the PHNs involved but recognises in rural areas this may not be possible. An evaluation took place in 2012 (O’Dwyer, Cahalane, Pelican- Kelly, 2015) in Cork, South Lee area, of a pilot project where a child protection PHN was employed to reduce the known barriers to communication between PHNs and social workers, the evaluation highlighted that the PHNs wanted greater links and collaboration with social workers and that social workers were not always aware that PHNs were involved with families that social workers were engaged with. However, both PHNs and social workers involved agreed that they, and children and families did benefit from a child Protection PHN and it was recommended it became a permanent post. To date, it is still the only area to have a child protection PHN in place (O’Dwyer, Cahalane and Pelican- Kelly, 2015). Some of the reasons given for the critical role of the PHN in child protection are that the service is universal and often the first point of contact for many families. The PHN is well known in the community and her/his role is non-stigmatising (Taskforce, 2012). In addition to supporting vulnerable families the PHN
also plays a critical role in identifying child protection concerns. Tusla is striving to provide a consistent national approach to prevention and family support and work collaboratively with all members of the team including PHNs (NDPHN and Shannon, 2014).

2.8.4.2 Child Protection

The annual report by Tusla states that there were 47,399 referrals to child protection and welfare services in 2016, 9% more than 2015. 40% (19,087) were child abuse concerns and 60% (28,312) were welfare concerns (Tusla, 2017). Twenty years ago, a review of the role of the PHN recommended that “each PHN has knowledge of legislation and guidelines in child protection and prevention of child abuse irrespective of the caseload profile” (DOH, 1997, p.7). Hanafin (2013a) in her analysis of child protection reports has found concerns regarding record keeping and non-adherence to the transfer policy of child records, as areas where PHNs need to improve in to minimise risk. Child Protection work requires PHNs to have a close working relationship and share responsibility with other health care workers in this area (DCYA, 2011a). As PHNs are designated officers and are in close contact with families they are in a key position to identify suspected cases and refer accordingly (Brosnan, 2008; Cawley, and Mannix McNamara, 2011; NDPHN and Shannon, 2014). Hanafin in (2013a) stated that the PHN has a threefold role in relation to child protection. Primary protection involves preventative measures, secondary require early detection and referral and tertiary protection refers to intervention or action taken. Reliable and valid methods of detecting child abuse need to be developed as professionals sometimes rely on intuition (Ling and Luker, 2000). PHNs should strive to put more emphasis on child health promotion programmes and lobby for more resources to ensure the preventative aspect of the PHN service is maintained (DOHC, 2000; DCYA, 2013). Continuing education for PHNs and all professionals involved is essential to ensure a high-quality service (Denyer, 2005; O'Dwyer, 2012). Hanafin, in (2013a) stated PHNs need to be supported through training and supervision however this professional supervision whilst in operation for social workers is not in place to date for PHNs.
2.9 Current challenges for the Public Health Nursing service.

The shift in care from the acute sector to primary care has provided many implications on the PHN service which will now be discussed. With international comparisons, the number of PHNs in Ireland compares poorly to other countries. Norway, a country the same size, has more PHNs whose work does not include any curative nursing and concentrate alone on preventive work (Clancy et al, 2013). In a similar study in England found that the percentage of nurses working in the community was 15.1% compared to 5% in Ireland (Royal College of Nursing, 2012), for further details See Appendix D.

The issues currently facing Public Health Nursing in Ireland are as follows: rising demand as discussed in section (2.2.1), increased dependency of clients in the community and patients requiring high dependency care to be maintained in their own homes (O’Dowd, 2013). The increase can be shown by the increase in the Home Care packages from 8,000 in 2008 to 15,986 in 2016 (HSE, 2016). The, average length of stay in hospital has reduced from 6.18 days in 2006 to 5.5 days in 2015 (DOH, 2016) due to increased demand on hospital resources. Surgical day cases have increased from 86,948 in 2006 to 152,556 in 2015 (DOH, 2016), leading to increased patient turnover. The, PHN service facilitates these early discharges of patients from acute care, who often need follow on clinical care such as wound dressings. This has led to an increase in demand of the Public Health Nursing services without any increase in resources, which in turn is impacting on the time PHNs would previously have had for preventative care (Begley et al, 2004). Prioritisation of clinical work at the expense of health promotion and disease prevention is inevitable due to the demand (Burke and O’Neill, 2010). Services, such as parent-craft classes and elderly surveillance are listed as being of the lowest priority (NDPHN, 2011). Stewart – Moore, Furber and Thompson (2012) in their study on post-natal care found that mothers would welcome more visits from the PHN in the early period, but they felt the PHNs were too busy. McNamara, Normand and Whelan (2013) found that the ability of people to live in independently, in the community depends on the appropriate supports, services and stated that access to the PHN is the key to accessing a range of services.

2.9.1 Universal Child Health Screening

Challenges are evident in meeting the current requirements for universal child health screening and school nursing services (NDPHN and Shannon, 2014). Findings from the DCYA (2012) show considerable variation in the percentage of children visited by a PHN
within the mandated forty-eight-hour period ranging from 50% in Meath to 100% in Mayo. The national target for the seven-nine-month screening check is 95%; figures show that this ranged from 22% in Galway to 100% in Cavan/ Monaghan community area (DCYA, 2012). Currently in Ireland children account for 25% of the population (CSO, 2016a), screening children at appropriate times as guided by the Best Health for Children guidelines is essential and failure to do this prevents early intervention. Significant differences have also been shown in the study by the ICHN in the provision of this service (ICHN, 2013b).

2.9.2 Geographical model of care

Pressure on the geographical model of care due to firstly, unequal need of populations, currently the sole criterion of population size is the basis for the PHN service (Hanafin, Houston and Cowley, 2002, p.69). Responses from the INMO (2013) survey indicated that they worked in areas with a population up to 5,000 (n=116). Hanafin and Cowley (2005) found that the mean average size of population per public health nurse was 1:4000. This is a significant increase in the ratio since 1995 when the average was found to be 1:3000 (INMO, 2013). Population needs can differ from area to area and Hanafin et al (2002) suggest the provision should be based on the needs of the population in each geographical area rather than the size to achieve an equitable service.

Secondly, due to falling staff numbers, therefore increasing vacancies, leading to fewer community nurses. In 2015, there were 1,436 Public Health Nursing Posts which had showed a drop of 24 from the previous year (NDPHN and Shannon, 2014). In CHO 4 there are 211 PHNs which shows a decrease of 3 from 2017 (HSE, 2018a). Findings, from an INMO study found that 87% of staff indicated that there was no relief cover for sickness or holidays and cross-covering was a major burden on their workload, with just less than 50% saying they often provide cross-cover (INMO, 2013).

2.9.3 Eligibility for the PHN service

Other factors which have increased demand on the PHN service are (a) the allocation of medical cards increasing, recent statistics show from the Department of health that the number of people with medical cards has increased on a year on year basis with 700,000 additional people being eligible for the PHN service since 2008, the current number of people with a medical card stands at 1,699,721 (DOH, 2013a; HSE, 2016). And (b) lack
of clarity on eligibility for the PHN services, as discussed earlier (2.7.1) some groups are legally entitled to the PHN service, whilst for others outside of these groups, it is up to the PHN and the ADPHN in the specific community area if this service is granted regardless of need, leading to inequity in service (INMO, 2013). O’Dwyer (2012) state that because of the inconsistency in eligibility, it leads to creating difficulties in the standardisation of the PHN service.

2.9.4 Deficits in information and communications technology

Deficits in information and communications technology (ICT) hinder a safe, effective and efficient PHN service (NDPHN and Shannon, 2014). Nationally there is an urban rural disconnect when it comes to the infrastructure such as broadband, a greater proportion of rural households had no internet connection when compared with urban households, the numbers being 31.2 per cent and 22.8 per cent respectively (CSO, 2016a). There is no availability of a national IT system in place to support PHN services or to use data collected by PHNs to plan or measure outcomes. There is very limited IT availability for staff in the community, 31% reporting to have to share with up to ten colleagues and over 5% having no access (DOH, 2013b) and creates substantial problems in the administration and delivery of the PHN service. There is an increased focus on the measurements of nursing activities and caseloads with the implementation of the health statistics record and whilst the development of the Population Health Information Tool (PHIT) and the Personal Health Record (PHR) for children has been welcomed and shown to improve outcomes the implementation of these two tools has not taken place nationally (Pye, 2011; ONMSD, 2012; McDonald, 2013). A modern PHN service should depend upon high quality information and digital technology (HSE, 2017b). The lack of ICT infrastructure by the PHN service and the absence of a digital information system continue to be a substantial challenge, to enable communication, co-ordination and continuity of care (HSE, 2018b).

All the above challenges will encroach on the PHN service whether operating in a rural or urban area, the following section will discuss the PHN operating in a rural area.

2.9.5 Rural area challenges

Regarding specific challenges in the rural area to the PHN service, there is a paucity of evidence in the literature and in past research in Ireland. Of the evidence available from the past reviews of PHNs, there is a suggestion that there, may be professional isolation
in rural settings. It was recommended by O’Sullivan (1995) that all PHNs should be supported with a community RGN to alleviate this isolation. One would have to look internationally for indications of specific challenges; Bushy (2002) who did a comparative analysis of the literature available, between Canada, USA and Australia on rural nursing, suggests that there are regional variations, but the recruitment, retention, and education of nurses is a shared concern across rural settings at an international level. It is difficult to generalise the findings of many studies as the definition of rural varied, between rural to extreme remote areas, but there is the suggestion there that there are fewer formal services and increased exposure to clients with many different conditions, so the professional’s generalist role is advantageous in providing a service in rural areas (Mills, Birks and Hegney, 2010). The findings from the literature suggest rural nurse retention is influenced by level of job satisfaction (Hegney et al, 2002). Most rural nurses have high public visibility, are known by many locals therefore retaining confidentiality can become difficult (Mills, Francis and Bonner, 2007). Bushy (2002) states that consequently, high public visibility can affect retention of health professionals in rural practice settings. Macleod et al in their research in Canada (2004) found that because many rural and remote nurses work alone or with little backup in their everyday practice, there are pressing needs for providing professional supports at a distance, both in person and using information technology.

Scotland one of our nearest neighbours, where approximately 20% of the total population live in rural or remote areas. Like Ireland they have an increasing ageing population with the largest proportion of over 65 predominately rural. Scotland too has a net outward migration in the 16-24 cohort due to employment and education reasons. MacVicar and Nicoll (2013) in their paper for the NHS supporting rural healthcare in Scotland, identified recruitment and retention as the key issues facing rural primary healthcare. Recommendations made to counteract this issue was to recruit students from rural areas, so that they may return to work in rural communities and an increased exposure to rural settings to students in training to prepare the students in the workforce. The Report, Going the Extra Mile (RCN, 2015) advocates a whole family approach to recruitment of staff, to relocate to rural areas for example partners to be assisted with employment, access given to schools and housing. Additional challenges identified by MacVicar and Nicoll (2013) were lone working and difficulties trying to obtain cover in your area for annual leave or continuous professional development.
In order to overcome these challenges, they recommend the following access to on-going education, peer support to decrease the professional isolation and to underpin this with an increase in use and availability of technology to improve the “fragility of rural practice” p.9. Scotland has had telecare projects in operation for some period, despite this MacVicar and Nicoll (2013) recommend upskilling of all staff to increase confidence with technology use in every day practice. Across all rural areas in Scotland MacVicar and Nicoll (2013) recommend nurses have a combination of both acute and community nursing skills similar to the “one stop approach” recommended by Parfitt et al in 2006 where nurses support self-care, empower patients and manage chronic illness (Scottish Executive, 2006). The RCN report (2015) also calls for the investment in ANPs to support the needs of the elderly population living in rural areas who have suffered due to the ongoing staff recruitment and retention issues, which would deliver a service closer to their homes and improve access to primary care services.

All the issues identified, contests the delivery of the PHN service daily. There is a tension evident between health promotion activities and providing clinical nursing service. Which leads us on to the debate whether the PHN role should remain generalist or become specialised?

2.10 Future of Public Health Nursing

Having taken account of the current challenges the retention of the PHN universal service is recommended (NDPHN and Shannon, 2014), however some reform and re-structuring of the service is necessary to maintain and deliver a high-quality safe service. The integration of the PHN service with the primary care teams will help to accomplish better outcomes. The last decade in Ireland as in Europe has witnessed various national public health policies and health promotion campaigns relating, to obesity, cardiovascular health, breastfeeding, alcohol awareness, smoking, sexual health, Travellers’ health and the health of other specific population groups. Many pertinent strategy documents and reports refer either directly to the actual or potential contribution of the PHN to their respective aims and activities; in some instances, this contribution can be inferred. Expansion of the service is indicated through continued professional education and furthermore, these documents may provide indicators for the development of specialised, advanced and other public health nursing practice.
2.10.1 Generalist versus Specialist Debate

The topic of specialism in the community nursing has been the subject of much debate. The term specialist in nursing can be traced to the turn of the 20th century (Doody and Bailey, 2011). Today in the UK there is a significant number of specialist nurses working in the community, which is reflective of the specialisation existing in the hospital sector. This has the potential to confuse clients and other health and social care professionals leading to role conflict/confusion and overlap (McKenna and Keeney, 2004). In the Republic of Ireland, the generic role of the PHN could lead to poor practice because of an inability to keep up-to-date in all relevant areas of practice (DOH, 1997; Pye, 2015). Throughout the western world, there is a move towards specialisation, increasingly questions are being asked regarding the worth of such positions and whether a return to generalist is the favoured position. Too many specialism nurses may lead to elitism, deskilling of the general nurses, tribalism among community nurses, a discontinuity of care, fragmentation of care and specialist nurses being out of touch with the big picture (Wilson-Barnett, 1995; McKenna, 2003; Clancy et al., 2013). McKenna (2003) expresses there is much negativity about specialisation in the community while others feel that a move away from generalist is unavoidable. The recent policy shift from acute care to community care has inevitably brought with it an increased need for community-based specialist nurses, due to the increased complexity of care, to compliment the current PHN service and to provide expertise to clients, as close to home as possible.

The Governments in Ireland and in the UK recognise the potential problems and call for caution in the pursuit of specialism (GOI, 1998; UKCC, 1999). There are significant differences between the role of community nurses in Ireland and those in the UK. In Ireland, the only move to specialisation is where there is a small number of Community mental health nurses, School nurses and tissue viability nurses working in the community (Pye, 2011). In contrast the UK have a large number, the United Kingdom Central Council for Nursing sees community healthcare nursing as a discipline with 8 specialisms:

1. General practice Nursing
2. Community mental health nursing
3. Community mental handicap nursing
4. Public health nursing/Health visiting
5. Community Children’s nursing
6. School nursing  
7. Occupational health nursing  
8. Nursing in the home/district

Likewise, in Northern Ireland, there are 11 different nurse specialities (McKenna et al., 2003).

In the Republic of Ireland, the PHN has a wide clinical remit visiting new-born infants and their mothers and in providing care to clients with a variety of health problems. Presenting a challenge for the PHNs to keep their skills enhanced and be familiar with best practice always. Pye (2011) asks whether one nursing profession can provide a service for such a large range of care groups and retain their professional competency.

It can be assumed, that if given the opportunity/choice that most of us, would prefer a specialist nurse (Scottish Executive, 2006). In McKenna and Keeney’s research (2004) over 85% of the members of the public agreed they would feel more confident when being treated by a specialist nurse. However, this study also showed that 58% of the public preferred one nurse visiting the home rather than a variety of different nurses, which is consistent with Fawcett-Henesy’s (2003) idea of a family nurse (Scottish Executive, 2006). In 1995 the National PHN Committee debated whether increased specialisation was a suitable route for the Irish PHN. The Commission on Nursing (GOI, 1998) stated that the specifically generalist role is recognised as a strength of the PHN service and recommended a continuation of this generalist and geographic focus (Clancy, et al. 2013). The Commission (GOI, 1998) called on an increase in specialists’ nurses but acknowledged that too many specialists would lead to confusion, misunderstanding and role conflict. It recommended key specialisms such as paediatrics, mental health and learning disability. The generalist role of the PHN has been identified as a strength of the PHN service (ONMS, 2012). There is a concern, a view that a generalist nursing role has an inherent value and that an increased focus in specialisation would undermine this important nursing function and would mean that there would not be enough generalists to meet the needs of the clients. Also, there is a desire for one main nurse visiting the home who has an overview of their individual needs and those of their family (McKenna and Keeney, 2004). This one nurse would co-ordinate interventions, be knowledgeable about onward referral in a timely and appropriate manner (Scottish Executive, 2006). The client’s main nurse should retain continuing responsibility for the care of the client.
including the evaluation of specialist nursing inputs into the care plan (McKenna, Keeney and Bradley, 2003).

2.10.3 Caseload management model

PHNs’ caseloads can vary in size and demographically, in 2006, the Scottish review of community nursing proposed a model very like the role of the Irish PHN (Scottish Executive, 2006). It recommended that services be co-ordinated with one key professional identified to provide the major element of care. The evidence presented by the Scottish Executive (2006) supports the retention of the generalist role of the Irish PHN. PHNs should remain geographically based (Clarke, 2004) however, PHNs working in their geographical areas need to be able to carry out health needs assessments, co-ordinate care and advocate for services to improve public health Hanafin, Houston and Cowley (2002) recommended a Public Health Nursing model based on vertical equity where service configuration is determined by population size and need. Vacancies in public health nursing posts need to be filled so there is equity in service delivery for clients (Pye, 2011; INMO, 2013). The separation of well-being activities and clinical caseloads is suggested due to the high curative demand on the PHN service and current health promotion policies (NDPHN and Shannon, 2014). One possible solution offered by Pye (2011) and tested is the introduction of corporate caseloads, caseload management in urban areas which could increase accountability, give greater opportunities for skill mix and health promotion. This is where one group of PHNs would concentrate and focus on children and families in relation to health and well-being and another group of PHNs supported by community registered general nurses would focus on the management of clinical caseloads in delivering general nursing care and end-of-life care. Issues of key importance to its implementation were identified on evaluation include resources such as personnel, education and IT support. (Pye 2015; Hanafin and Dwan O’Reilly, 2015). Discussion on whether this method of case load management, is possible in a rural area is to be debated and to date it has not been trialled.

2.10.2 The Expansion of the PHN Service

The expansion of the PHN role is recommended to promote quality of patient care and its development is fundamental to the Health Service (DOH, 2011). It is to include the introduction of Clinical Nurse Specialists (CNS) and Advanced Nurse Practitioners (ANP) to support the generalist PHN service, with the primary aim to improve; patient
access to services, continuity of care and follow-up leading to improved care and compliance (Begley et al, 2010). Ireland is unique in that it has set up a comprehensive programme/framework to register and accredit all ANP, which other countries are lacking leading to ad-hoc development of posts (NCNM, 2008). The provision of CNSs across the country is both patchy and inconsistent. The current number of CNSs directly employed within the PHN Service is 65.5 positions. Currently in the Kerry region there is no CNS within the PHN service. There are two CNS posts within the PHN service in West cork, covering the speciality of wound care and Diabetes and one in North cork, CNS in wound care. There are different governance structures in place across the country in respect of clinical nurse specialist services and consideration will need to be given to this (NDPHN and Shannon, 2014).

There are currently two Advanced Nurse Practitioners (ANPs) within the PHN Service. There is an ANP in Child Health and Parenting in Donegal and an ANP for Older Persons in Dublin South City (NDPHN and Shannon, 2014). The ANP promotes wellness, offer healthcare interventions and advocate for healthy lifestyle choices for patients/clients, their families and carers in a wide variety of settings in collaboration with other healthcare professionals, according to agreed scope of practice guidelines. They utilise advanced clinical nursing/midwifery knowledge and critical thinking skills to independently provide optimum patient/client care through caseload management. Currently in Ireland the ratio of ANP is 0.2% of the total nursing profession (OECD, 2016). Development of CNS and ANP roles would benefit both the PHN service and the client, by providing high quality nursing care; and having expertise (in relation to evidence-based practice in the management of their disease) situated in the primary care setting as opposed to the acute sector (GOI, 1998; NCNM, 2001b; NCPDNM, 2004). The services provided by the CNSs and the ANP will improve access to screening, treatment and management of diseases such as COPD, Diabetes and tissue viability (NCPDNM, 2004).

According to the SCAPE study (Begley et al, 2010) Clinical Nurse Specialists can also be nurse prescribers facilitating management of care at point of access. This will extend to intravenous (IV) cannulation and administration of IV medication and advanced assessments such as ECGs and auscultation (Begley et al, 2010). GP’s seemed less

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14 SCAPE is a study on the impact of specialist and advanced practitioners’ roles in Ireland

15 ECG is an electrocardiogram is where the electrical activity of the heart is recorded
convinced that this is a good idea and some community nurses also disagree (McKenna and Keeney, 2004). Specific areas for ANP appointments are recommended within dementia care, chronic disease such as Diabetes, within child health, Child protection and welfare and within end-of-life care (Doody and Bailey, 2011). In the past CNSs in the U.K. experienced difficulties when introducing new ideas when there was a lack of collaborative working practices (Austin, Luker, Ronald, 2006). It is vital for the PHN service that an environment is provided which will benefit from the CNSs skill, so a safe high, quality nursing service can be provided (Booth et al, 2003; Begley et al, 2010; Wickham, 2011).

In Summary DPHNs envisage that the PHN service will be delivered by a skill mix of nursing staff, generalists supported by CNSs and ANPs and supported by RGNs, Healthcare Assistants and Home Help. Central to addressing population need is workforce planning and the optimising of skill mix as well as the fostering of positive work environments (WHO 2015b). However, PHNs need to be careful and stay within their scope of practice, as in some cases, PHNs are filling gaps in services that may be better provided by other healthcare professionals (Begley et al, 2004; Brady et al, 2007).

2.11 Conclusion.

To summarise the role of the PHN and has remained broadly unchanged since 1960, despite been subject to review at intervals since its inception in the 1960’s. The role of the Irish PHN is unique due to the broad nature of the role, o has a dual-purpose curative and preventative across the lifespan very different to other countries as outlined in Appendix C. PHNs are the largest and longest nursing group in the community and remain geographically based rather than based on a needs assessment of the population in an area. The PHN role has been influenced by many health strategies, where the emphasis has shifted from the acute sector to focus on primary health care. Improving public health is at the forefront of all the Irish, European and world-wide governments’ policies. With the focus on Primary healthcare health services including the PHN service currently face the unprecedented challenges of rising demand due to an increasing ageing population, and as the result of ten years of financial austerity. Hospital stays are shorter leading to increased demand on the clinical role of the PHN service. Prioritisation of Clinical work due to demand has led to the detriment of the preventative role of the PHN due to limited increases in PHN numbers despite the shift to Primary health care.
Greater emphasis in healthcare policy is now on how best people can be helped to not just live longer but to stay healthy. Nurses need to use all opportunities to provide accurate and up-to-date health education so that people are supported to make good lifestyle choices (Cowley, et al, 2015). PHNs are ideally suited and uniquely placed to respond to public health challenges as they understand the risks of individuals but also know the population and the communities they work in (Donovan, 2015). However, there is an increasing need now for all nurses to become drivers of public health and promote health in their clinical practice (RCN, 2016). At an individual level for PHNs, where there is increased demand on curative nursing, the emphasis is now on making every contact count (Bennett, 2012). In the context of care and reform PHNs play an integral role in delivering and treating patients in their home and is continuing to evolve to the growing demand for health care service in primary care.
Chapter 3 Methodology

3.1 Introduction

Methodology is a “theory or analysis of how research should proceed” (Harding, 1987, p.3). This chapter describes, clarifies and justifies the research methodology employed to address the research question, involving the study design, instruments utilised, sample, data collection process and data analysis. This chapter will begin with outlining in detail the research methodology approach, design and methods used and proceed to discuss the data analysis and ethical considerations and conclude with an outline of the limitations and delimitations of the research.

This study is based on an ethnographic approach using an interpretive paradigm to understand the practice of PHNs in rural areas of Kerry and Cork. A qualitative research design was used due to the holistic and humanistic nature of this research. A timeline of the Research (Gantt Chart) is available in Appendix E.

3.2 Aim of research study.

The primary aim of the research study is to understand and gain insight into the role of the Public Health Nurse in rural areas of Kerry and Cork. The care being delivered by the PHN service has grown in complexity due to increased life expectancy, changes in demographics leading to increased dependency, shorter hospital stays, complex cases (adults and children) requiring twenty four-hour nursing-care in the community, coupled with infrastructure challenges, health inequalities and Childcare legislation (INMO, 2013; NDPHN and Shannon, 2014; CSO, 2016b). For these reasons, significant challenges have been placed on the PHN service. The study presented here aimed to investigate the role of the PHN working in rural areas and the study objectives are outlined as follows; (a) to identify the unique challenges faced by PHNs operating in rural locations and the challenges facing clients from the PHNs’ viewpoint, (b) to inform policy around the delivery of Public Health Nursing in primary care in remote rural communities, (c) to investigate the extent (if any) information technologies are being used by PHNs operating in rural settings and (d) to provide an opportunity for PHNs to reflect on their own role through the innovative use of research diaries. Exploring the role of the PHN can throw light on the profession and generate knowledge that can improve and develop the PHN service.
3.3 Research Approach.

The use of an ethnographic approach was taken in this research, ethnography is always concerned with studying culture and understanding the meaning of actions and events of people, mostly commonly it is described as interpretive inquiry and is acknowledged as the most basic form of social research (Hammersley and Atkinson, 1995; Crotty, 2005). Qualitative research is based on interpretivism; qualitative researchers believe there are multiple truths based on the participants' view of reality (Dodd, 2008; Farrelly, 2012; Parahoo, 2014; Polit and Beck, 2016). Therefore, different people may have different interpretations of the same phenomena (Farrelly, 2012; Parahoo, 2014). Farrelly (2012) describes interpretivism as being based on two concepts, firstly there is relativist ontology, where reality is perceived as being inter-subjectively based on meanings and understanding at social and experiential levels. Secondly there is transactional or subjectivist epistemology, where it is thought that we cannot be separated from what we know. There is a clear link between the researcher and research subject (Farrelly, 2012).

3.4 Research Design

A research design is the plan of how, when and where the data is to be collected and analysed (Parahoo, 2014). Research is the process of collecting, analysing, and interpreting data to understand a phenomenon (Leedy and Ormrod, 2015). Qualitative research has been described as using "a holistic perspective which preserves the complexities of human behaviour" (Black, 1994, p.425). In 2016, Polit and Beck described qualitative researchers, as studying things in their natural settings attempting to make sense of/or interpret phenomena in terms of the meanings people bring to them. Subsequently there is increasing appreciation for using qualitative research in areas of health research (Harris et al, 2009). Ethnography differs from a case study in that a case study studies a person or solidarity event while ethnography studies an entire group that shares a common ethos (Leedy and Ormrod, 2015). Creswell (2014) describes "ethnographies, in which the researcher studies in a natural setting over a prolonged period of time by collecting, primarily, observational data" (p. 14). The ethnographic approach in this study involves the researcher gaining access to enter the workplace of the participants and building a rapport with the participants. Instead of direct observation and watching what happens, the participants will self-report in their solicited diaries and
through this data collected, the researcher will identify the norm, beliefs and other factors. The goal is to understand the PHN role from their emic\textsuperscript{16} perspective.

3.5 Population, sample and sampling technique

There are several considerations researchers must consider when choosing a sample method (Kandola et al., 2014). These considerations include the research question, the target audience and the researcher's own experience (Kandola, et al., 2014). For the purpose of this study the researcher chose a target population of all registered PHNs working in the HSE South region of Kerry and Cork who worked in rural areas. Once the researcher had identified the target population, then sampling techniques was considered. According to Bowling, (2009), there are two main types of sampling techniques, probability sampling and non-probability sampling. Probability sampling is ideal with quantitative research where a high level of control is necessary (Kandola et al., 2014). Non-probability sampling is defined as the selection of participants from the population using non-random methods (Polit and Beck, 2016). Such methods include convenience sampling, purposive and snowball sampling (Kandola et al., 2014). These methods are used where the researcher does not have access to the data needed to use random sampling techniques. Advantages to using this method are it allows the researcher to make descriptive comments regarding the sample if desired it is quick, non-expensive and convenient. Disadvantages, it can be viewed as biased as the participants are not chosen at random and also; they might not represent what another population thinks (Kandola et al., 2014).

For this study a purposive sampling technique was adopted. It is evident from the literature that this is a popular sampling method to use by qualitative researchers. Parahoo (2014) outlined that a carefully chosen sample can deliver data representative of the population from which the sample is drawn.

Inclusion criteria: All available PHNs who fitted the following criteria were eligible for selection

- Registered Public Health Nurse
- Working in a rural location
- Working in the designated area in Kerry and Cork

\textsuperscript{16} Emic means to understand from the natives' point of view in this case the PHNs' view (Parahoo, 2014).
Peninsulas connected to the mainland by causeways will be included

Exclusion criteria: Islands with a full-time PHN

3.5.1 Sample size and recruitment.

A sample is a subset of the defined population who are selected to participate in the study and is intended to reflect all the characteristics of that population (Gerrish and Lacey, 2012). One of the critical responsibilities in designing a research study is to decide on the number and characteristics of the participants best suited to provide the information and to meet the objectives of the study (Parahoo, 2014). The Director of PHN in Kerry and two Assistant Directors in Cork were committed and acted as gatekeepers allowing access to the research sites for this study. They acted as a referral point for the researcher and disseminated information regarding the study including the distribution of the information letter on the study (see Appendix F) to all PHNs in rural areas in the region. They were involved in the initial recruitment stage in that they forwarded the names and contact details of the PHNs who were interested in finding out more about the study and might be potential participants in the study to the researcher. Once the researcher was aware of all interested PHNs, the researcher contacted each of them personally by phone and explained in detail what the aims of the study were and what it would mean to be a participant. Most were very willing and excited about the study and out of the total 18, fourteen agreed to participate, (see table two below to illustrate the sample distribution).

Table 2 Sample Distribution

<table>
<thead>
<tr>
<th>Area</th>
<th>Quantity</th>
<th>Qualification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerry County</td>
<td>7</td>
<td>PHN</td>
</tr>
<tr>
<td>North Cork</td>
<td>4</td>
<td>PHN</td>
</tr>
<tr>
<td>West Cork</td>
<td>3</td>
<td>PHN</td>
</tr>
</tbody>
</table>

3.6 Research Method

Ethnographers seek to gain an emic perspective, or the 'native's point of view' of a specific culture (Hammersley and Atkinson, 2007). This means that they try to look at the culture under study from the inside; through the meanings that the members of that culture
live with. Nursing first used ethnographic research when working with different cultures in community health, but this has refocused on the culture of nursing itself (De Chesney, 2015). This study will employ the ethnographic research method with the aim to obtain a holistic view of the subject with theory generated through reports of the PHN role as it is (Hammersley and Atkinson, 2007). Ethnography is where the “researcher studies the shared patterns of behaviors, language, and actions of an intact cultural group in a natural setting” (Creswell, 2014, p.14). The primary research method in this study includes the diary/interview method where solicited participant diaries are used over a particular time-frame in conjunction with interviews to gain a complete picture as possible and thus generate rich data. Given that the research sites are geographically disparate in this ethnographical study, the use of diaries can be justified as it enabled the researcher to obtain scientific observation, in settings from which the researcher was absent (Elliot, 1997) with the intent of revealing the everyday experiences of the individual subjects without direct observation.(as previously outlined in section 3.4) Zimmerman and Wieder (1977) also advocate using the diary-interview method in accessing phenomena which are not amenable to observation because they are unfocussed or take place outside set time or environmental boundaries (Elliot, 1977). Additionally, using Crotty’s typology (2005) allows us to locate the use of diaries within a research framework that derives its legitimacy by following a clear line of epistemology right through to research methods. Crotty (2005, p.2) proposes that each researcher should ask themselves the following questions when striving to justify the research option taken, firstly, what methods do we propose to use, Secondly, what methodology governs our choice and use of methods. Thirdly what theoretical perspective lies behind the methodology in question and fourthly, what epistemology informs this theoretical perspective. Crotty (2005) provides a framework where the participants are at the centre of the research and it is the participant’s insight and understanding of an event or experience that gives it meaning (Sarantakos, 2005) and through this process knowledge is construed.

Researchers can use solicited diaries as a method of accessing participants understanding and interpretation of their world over time and not just in the snapshot of a single time (Alaszewski, 2006). Diaries offer the possibility of documenting the present and are a contemporaneous source of data (Corti, 1993; Hyers, 2018). Zimmerman and Weider (1977) subsequently used the diary data as a means of stimulating subsequent interviews. In this instance the diaries served two separate though mutually beneficial purposes,
firstly the data from the diaries served as independent data in its own right and secondly the diary data served to stimulate and generate subsequent verbal data from the semi-structured interviews.

The importance of careful preparation by the researchers for the participants' interviews is a subject where there is no dearth of literature. Arthur and Nazroo (2003) provided a framework for preparing a guide for an interview, comprising of an introduction, opening questions, core questions and closure. One of the key features of semi-structured interviews is the open-ended questions, which allows flexibility and encourages the narrative to unfold (Kvale and Brinkmann, 2009). Interviews are primarily used to understand participants' perceptions and experience (Corbin and Strauss, 2015). Blandford and Rugg (2002) states that people’s ability to self-report facts verbally is limited. Flick (2014, p. 222) states “practice is only accessible through observation.” Therefore, the solicited diary data provided the evidence of the PHNs daily practice and the semi-structured interviews gave the researcher the opportunity firstly to explore the diary responses and validate the emerging themes and encouraged freedom of expression by the participants and a chance to follow up on any interesting avenues that arose within the interview.

3.7 Data collection methods

The main data collection techniques that were used for this research are solicited diaries and semi-structured interviews, taken together as the diary/interview method (Zimmerman and Wilder, 1977). Constancy is an important component of data collection (Parahoo, 2014) the researcher tried to ensure that the timing of the data collection, the instruments used, and the data collection procedures was the same for each participant. A detailed overview of the methods used will be given in the following sections.

3.7.1 Solicited Diaries

Solicited diaries were used in the first phase of data collection. There are many definitions of what a research diary constitutes the following are some; Hyers (2018) define diaries as first-person observations of experiences that are recorded over a period of time. Likewise, Sheble and Wildemuth, (2009) state diaries capture life as it is lived. However, one the researcher could not surpass described research diaries as “little experiences of everyday life that fill most of our working time and occupy the vast majority of our conscious attention” (Wheeler and Reis, 1991, p. 340). Diaries are more likely to capture
ordinary events and observations that might be neglected by single recording methods as participants may forget them, undervalue or view them as unimportant (Wheeler and Reiss, 1991; Elliott, 1997; Bolger, Davis and Rafaeli, 2003). Nonetheless, the primary concern with the use of diaries could be argued is the issue of fatigue (Wiseman et al, 2005). In relation to diary completion, fatigue has been described as a form of “conditioning effect whereby the diary period lengthens, participants become tired of keeping records and may become less thorough in their reporting” (Wiseman et al, 2005, p.395). To minimize the effect of fatigue in this study the following plan was devised, firstly each participant was met personally by the researcher with the diary and was given ample time to discuss any concerns, reassurance was given that their diary entries were anonymous, identified by a letter, no name was to be placed on the diary, the researcher alone had the code to link the diary with the PHN and the researcher and her two supervisors were the only people to have access to the PHN diary. Secondly, post diary completion interviews would take place to reflect on the diary entries all which would be used to produce the findings of the research study.

3.7.1.1 Designing the Diaries

To devise the diaries, a lot of reading and reflection on the researcher’s part and discussion took place between the researcher and her own colleagues and supervisors, on what format the diaries should be, how best to capture a PHN day using a diary, should the diaries be unstructured, semi-structured or structured (Sheble and Wildemuth, 2009). Should there be specific questions, be prescriptive/rigid and risk missing out on events, or open and unstructured, leaving it to the PHN on what to write to gain maximum data on one hand or potentially risk minimal data if too open. A key aspect of the diary was how long it would take to complete, Marino, Minichiello and Browne (2003) expressed that if a diary entry required more than five to ten minutes per day to complete then the reliability may be compromised. As each PHN was in a different area, each day could be different for every participant. The researcher, along with the guidance of her two supervisors, decided to leave the diary as semi-structured, a sample of diary entries was drawn up by the researcher and reviewed by her supervisors, to give an exemplar and attached to the inside cover for all participants to refer to. Two versions would be offered paper-based and electronic. The paper diaries were A5 in size, hard-covered, durable and easily portable, allowing the participants to carry them around with them (Bolger, Davis, and Rafaeli, 2003). A pilot test of this diary took place amongst the researcher’s own
colleagues, as diary forms that seem straightforward to researchers may pose unforeseen complications for participants (Bolger, Davis and Rafaeli, 2003).

3.7.1.2 Administering the Diaries

To distribute the diaries, an appointment was arranged via telephone by the researcher to meet at a time of the participant’s choosing, each participant was met in their natural setting, mostly at their base the health centre. A choice between a paper-based diary (P&P) and an electronic diary via USB key was offered. All the candidates opted for the paper diary, this is in keeping with the literature, in that participants are happier with familiar instruments they use most and in this case with PHNs paper and pen (Bolger, Davis and Rafaeli, 2003; Hyers, 2018) The paper diary offered the participant the opportunity to review what they had written and make a change if so desired, this is congruent with the literature that found that “participants strongly favour the ability to retrace one or several steps” (Bolger, Davis, and Rafaeli, 2003, p. 597). The alternative of having handheld voice-recorders could not be offered to each participant but was considered, due to the limited resources of the researcher. None of the participants had access to HSE funded smartphones which could have given them the option also to voice record their experiences, so this was not viable, this issue was highlighted in Chapter 2 as one of the challenges to PHNs is the lack of ICT infrastructure. 17 A detailed explanation was given on the completion of same and written clear instructions were available on the first page for the participants to refer to. Each candidate was asked to complete the diary, two entries per day morning and afternoon, two days a week for six weeks ideally to capture Monday to Friday sequence. Effective training in diary use increases compliance and reduces errors (Stone and Shiffman, 2002).

The data collection commenced on the week of the 13th of February in all locations and ran for six weeks, ideally completing on the week of the 28th of March, however due to annual leave, two-week extension was given, and all diary data was completed the week of the 12th of April. All diaries were collected personally by the researcher who met the participant and feedback was taken on how they found the diaries and stored by the researcher. A date was then set with the participants, in June for the semi-structured interviews. June was picked by the researcher to have the data collected prior to the

17 Since the data collection has taken place, it is worth noting all PHNs in Kerry in September 2017 have received a smartphone.
commencement of the peak holiday season where the participants may not be available or not be able to commit to an interview due to time constraints. The diaries were read, and synopsis of each day was made by the researcher. Denscombe (2014) suggests data from a previous phase of the research is a useful method of informing the next phase.

3.7.2 Interviews

A first plan of the draft interview was produced and discussed with the researcher's two supervisors (Schreiber, 2001). The researcher had looked at a similar study in Galway which had looked at the workload and the role of the PHN (Begley et al, 2004), the use of solicited diaries was not used in this study, however semi-structured interviews were carried out and what interview questions if any would be valuable. The researcher had to take cognisance of the research question and decide what questions would best obtain the information required. A specific question, on what it was like to be a PHN in a rural area was included as the researcher felt this information was lacking in some of the diaries certainly not all. Rapley (2001) points out that it is essential that the researcher owns the questions. Changes were made, and a completed draft was produced which was then used for piloting. The researcher used this draft to help guide the interviews rather than use it prescriptively which allowed for spontaneity (Rapley, 2007). A pilot interview took place with one of the researcher's colleagues at the end of May, with the focus on the layout, the question order, the wording of the questions and the relevance and clarity of each question (Polit and Beck, 2016). It also gave the researcher an opening to fine tune the interview technique and an opportunity to refine the draft (Polit and Beck, 2016). Interviews are one of the most common ways of collecting qualitative data, as interviews enables participants to explain phenomena in their own words and provides an opportunity for the researcher to understand a particular topic in more depth (Holloway and Fulbrook, 2001).

The semi-structured interviews took place in the participants' natural setting the health centre, apart from one which took place by the participant choice in the researcher's car at a place which was selected and convenient to the participant. The actual setting and atmosphere of the interview are important to enable the participant to speak openly about themselves and their experiences (Kvale and Brinkman, 2009). At each interview, the researcher had the participant's diary present for reference if needed by both the participant and the researcher and to validate that it was their diary. One participant chose
to read the diary in full before the interview to refresh what they had written. Two skimmed over what they had written, whilst the others validated it was their writing they chose not to look at it. The interviews followed by guidelines described by Kvale (1996) which include at the start explaining the purpose of the interview, the voice recorder and asking if the participant had any questions before commencement.

The researcher began the semi-structured interviews by gaining demographic detail and leading then onto a day to day synopsis on what they themselves had written in their own diary and asked if they agreed what the researcher had understood from it. The draft interview was similar but not identical in each case (see Appendix H), as each diary steered the draft for the individual participant’s interview. The researcher asked open-ended questions allowing participants to elaborate and asked for additional information (Barbour, 2008), by using phrases such as could you describe further/ can you talk me through certain accounts from their diaries. Charmaz (2006) states how a competent researcher forms questions to obtain rich data while at the same time avoids imposing preconceived concepts. Each participant was asked before the conclusion of the interview had they anything they would like to say or add giving them the opportunity to discuss any issue that had not been mentioned that they felt was important (Erlandson et al, 1993). All the interviews were recorded with permission using an IC Sony digital recorder.

3.8 Data Analysis

In qualitative research it is recommended that the researcher should be the person who both interviews and transcribes (Easton, McComish and Greenberg 2000). In this study this was the case, all the interviews were transcribed using Sound Organizer Sony version 1.5 in Microsoft Word and it gave the researcher an opportunity to familiarise myself with the data. To ensure authenticity, the interviews were transcribed verbatim and included incomplete sentences, repetitions and poor grammar (Bazeley and Jackson, 2013). Following transcription of each interview, the script was re-checked against the audio file to ensure accuracy prior to analysis.

Thematic analysis is a method for “identifying, analysing and reporting patterns (themes) within data” (Braun and Clarke, 2006, p.6). One of the criticisms of qualitative research from outside the field is that “anything goes” (Braun and Clarke, 2006, p.26). Labuschagne (2003) states that “for many scientists used to doing quantitative studies the whole concept of qualitative research is unclear, almost foreign, or airy-fairy not real
research” p.1. Nonetheless, qualitative research does provide methods of analysis that should be applied rigorously to the data (Braun and Clarke, 2006). Miles and Huberman (2002) claims there are six approaches to data analysis that are common to all approaches of qualitative research. They describe them as coding the data, reflecting on what appears, finding similarities/differences, expanding on these, elaborating on a set of generalisations and forming theory from these generalisations. Corbin and Strauss (2015) outline analytical questions to be used when analysing, firstly asking sensitising questions such as what the data is saying, who is saying it and how do they define it. Secondly, asking theoretical questions trying to decide the relationships and thirdly asking practical questions where the direction should go to build the concepts. Braun and Clarke (2006), described analysis as going through six phases also as previously mentioned and provides a framework for data analysis.

The framework outlines the six phases as:

1. Familiarising yourself with the data. 4. Reviewing themes.
2. Generate initial themes. 5. Defining and naming themes.

This framework offered the researcher an accessible form of analysis which would help the researcher to build an accurate reflection of the entire data set. Inductive analysis was used which is described as a process of coding the data without trying to fit it into a pre-existing coding frame or the researcher’s preconceptions (Braun and Clarke, 2006). In this sense the researcher mindful of her own preconceptions endeavoured the report was data driven (Braun and Clarke, 2006).

3.8.1 The use of a CAQDAS

Data analysis in this study was aided by the computer software NVivo 11. The use of Computer Assisted Qualitative Data Analysis Software (CAQDAS) is well established in qualitative methodology and it has its proponents and critics (Kelle, 1995; Corbin and Strauss, 2015). CAQDAS is a term introduced by Fielding and Lee (1998) that refers to a broad variety of software now available to support data analysis. CAQDAS can facilitate, in organising data and for checking for consistency and frequency in data, to keep a running log of memos and provides easy access to what has already been done.
(Weitzman, 2000; Bazeley, 2007; Corbin and Strauss, 2015). However, it does not do the analysis for you which is one of the common misconceptions, while it does assist it is ultimately the researcher who interprets, examines and documents the data (Bringer, Johnston and Brackenridge, 2006). Weitzman (2000) describes how there is an expectation that CAQDAS can enhance rigour, but states this is not the case, however he does concede that it does make the analysis process more transparent. Critics fear that using computers in analysing qualitative data will alienate researchers from their data (Seidel and Kelle, 1995), however it should be viewed as an additional hand in qualitative data (Bazeley, 2007). Bazeley (2007) claims when using CAQDAS there is nothing preventing a researcher taking out a pen and paper if that would help the researcher be closer to the data to jot down ideas or to make links between data.

While there is a wide range of CAQDAS available the researcher chose to use NVivo, because it has been used successfully in the analysis of grounded theory studies (Bringer et al, 2006). Additionally, the Institute of Technology Tralee, (ITT) also had provided training on the software programme NVivo and its use was available free to the researcher. NVivo is a product of QSR International and was developed from their original software NUD*IST. The researcher used the latest version of NVivo which is NVivo 11. Data corpus which means, all the transcripts both the synopsis of the diaries and the interviews were imported into NVivo. The process of data analysis was conducted in accordance with Braun and Clark (2006) analytic process, the following figures are used to outline how the researcher combined Braun and Clark’s analytical process with NVivo.

![Figure 1 Coding Process - Phase 1](image)

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18 QSR International Pty Ltd, Doncaster, Victoria, Australia.
3.8.2 Coding Process

Before discussing coding, the researcher used the following definition by Saldana (2013, p.3) who defines a code as “a code in qualitative inquiry is most often a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data”. Coding involves the analysis of textual data into segments, examining similarities and differences and grouping similar data together (Bazeley and Jackson, 2013). The researcher used the bottom-up approach where the data was analysed line by line and coded. Codes that were similar in definition and content were merged. To ensure there was not an endless list of codes, each was described and the content of the nodes\(^\text{19}\) regularly reviewed (LaRossa, 2005; Bazeley, 2007). NVivo also has a function whereby coding stripes can be turned on and it shows which code a particular piece of data has been assigned to; it also highlights what data has been coded.

During the coding process when reading the data, the researcher asked questions of the data such as what is happening here, what is the participant saying (Strauss and Corbin,

\(^{19}\) A node is the name used in NVivo for codes where conceptual similar data is grouped and stored.
Coding moved from open coding to more focus axial coding whereby coding hierarchy was built using code categories that related to each other (see figure, 3. below).

The higher level of abstraction was aided by the Modeler function in NVivo and by written memos and the researcher’s journal. The Modeler function in NVivo presented the codes in diagrammatic form which helped the researcher to visualise the codes and move from open coding to axial coding/ coding on in NVivo. It could show also if there was any visual variance in the data and to compare and check for consistency between the research sites Kerry and Cork, as shown in the following figure 4.
3.9 Reflexivity

Reay (2007, p. 611) argues that reflexivity is "about giving as full and honest an account of the research process as possible, in particular explicating the position of the researcher in relation to the research. During the research process, I have aimed to be transparent, I acknowledge that as an "insider" that I had to be mindful of my behaviours and actions when interacting with the participants and reiterate with them that even though I myself was a PHN, the data alone and only the data would produce the findings. I was mindful that I could not make the findings more positive than they were (van der Riet, 2012). Total detachment as a PHN was unrealistic and as van der Riet (2012) states can actually hinder the research process. My own experience and knowledge as a PHN gave me an advantage on that I had a greater depth of understanding of the context of the data. Also, the researcher recognises that it is difficult not to be influenced by the participants (Jootun et al, 2009). One important strategy in qualitative research and in this study is that the researcher remained reflexive of her own preconceptions that they bring to the study and the influence of these on the research (Holloway and Fulbrook, 2001). The researcher maintained her own personal reflective journal, where she recorded her thoughts, ideas and any issues that arose during the data collection process, see Appendix I. Also, the
research journal helped the researcher to record her own feelings on what the data was saying to ensure that the researcher represented the data accurately, in that the themes were grounded in the data. The research journal also was used to make connections between the data by the researcher. NVivo was particularly useful here, by using the text word/phrase search to validate, when the researcher thought a topic was mentioned a lot and to ensure it was not the researcher’s own pre-conception. In addition, NVivo was advantageous when seeing was there any significant differences with participants in what was presenting between Kerry and Cork by using searches by attribute.

3.10 Ethical consideration

Ethical consideration is described as “not an option but a fundamental feature of all good research” (Denscombe, 2014, p.306). Nursing research studies require the permission of an ethics committee, because the researcher is obliged to take into consideration the implications of the proposed research for the participants (Ingham-Broomfield, 2015). This study was conducted in accordance with the Institute’s Research Ethics and Integrity Codes, Policies and Procedure (ITT, 2012) and in accordance with the principles of the Declaration of Helsinki (2000). As such, the study incorporated the following ethical research elements:

- Participation was entirely voluntary.
- Informed consent, all participants were provided with a letter of information to make an informed choice and their written consent was recorded on two copies, all participants retained their own copy.
- Participants’ right to withdraw, anonymity and confidentiality were respected.
- All paper and electronic data, including audio were stored in the researchers’ office in accordance with the Data Protection Act (1998 and 2003).

This research study has received ethical approval, where the project was deemed to be at a minimal risk level. In addition, gatekeeper access was negotiated to each site through the relevant Director of PHN.

3.10.1. Informed Consent

Parahoo (2014) recommends nurses must consider the four rights of participants when conducting research which include the right to; full disclosure, anonymity and confidentiality, self-determination and the right not to be harmed. During the research
process, every effort was made to protect the rights of the participants in this study. This study was guided by the principles of beneficence, respect for human dignity and justice (Polit and Beck, 2016). The selection criteria were applied to all participants in the Kerry and Cork HSE areas. Eligible participants were invited to enrol in the study by the researcher and met by the researcher at a time and place convenient to each participant. They were provided with a participant information leaflet (See Appendix F). The information leaflet described the rationale for the study, the study protocols and a sample of the consent form. Participants were made aware that participation was voluntary and of their ethical right to withdraw from the study without giving any reason (Ingham-Broomfield, 2015). Based on the principle of respect, participants were reassured that confidentiality would be maintained and the participant’s identity would not be linked to any commentary source and would not be identifiable in the study. Denscombe (2014) outlines confidentiality as an essential feature and participants need to feel assured that information shared will be treated as. In order to retain anonymity, each PHN participant was allocated a code number 1a to 11a. After giving as much information as possible the researcher sought informed consent. Obtaining the participants’ consent is vital after full explanation of the study’s intent prior to its commencement. Each participant was requested to sign a consent form agreeing to participate and to the recording of the interviews. Reassurance was given that all recorded data would be stored and subsequently destroyed as per the Institute’s policy. Once informed consent was gained by the researcher data collection began.

3.11 Rigour and trustworthiness.

As discussed earlier in this chapter, a fundamental benefit of diary/interview method is that they permit the examination of reported events in their natural setting (Reis, 1994) and limiting bias from a contrived setting and the researcher. Another is the reduction in retrospection by minimising the time elapsed between an experience and the account of the experience (Bolger, Davis and Rafaeli, 2003). Thus, one advantage of this study, is in the diary-based data which “lies in the reduction of systematic and random sources of measurement error and with it, the increase in validity and reliability” (Bolger, Davis and Rafaeli, 2003).

To ensure trustworthiness in this research study, Freisen-Storm’s (2015) strategies to ensure reliability were adopted. These include method and data triangulation, member check and thick description. Craig (2010) defines triangulation as using more than one
method to collect data to ensure credibility of the research. The purpose is not too necessarily to cross-validate data but to capture different dimensions of the same phenomenon (Streubert and Carpenter, 2011). The aim of triangulation is to apply consistency to data collection. During the data compilation and analysis, the researcher provided the participants with an opportunity to clarify and explain entries which gives this study more trustworthiness and hence validity (Alaszewski, 2006). The researcher reviewed and discussed aspects of the study with her supervisors at the ITT.

In qualitative research, member-checking is a technique used by researchers to ensure the accuracy and reliability of the study. Throughout this research, to ensure respondent validation, the researcher has kept the participants informed continuously within the data collection process, by validating the data entries in their diaries, and in their interview transcripts, where each received a copy and were asked for comments on same. Furthermore, member checking was a consistent process with my supervisors, through supervision meetings, where we discussed and analysed the study. NVivo, made the research analysis process transparent to the supervisors, as it displayed what the participants were saying at a glance.

The term thick description refers to the detailed account of cultural and social relationships and putting them into context (Holloway, 2005). Because of the possible influence of the researcher on the research findings, I kept a research journal to help remain reflexive of the thoughts and ideas that I was bringing to the study. Qualitative researchers are advised to describe their studies well and compare interpretations within findings in the literature (Miles and Huberman, 2002; Parahoo, 2014). The researcher has attempted in this study to give sufficient detail and illustrate thoroughly the research process, in association with the literature, plus any trials/challenges, including the role of the researcher, the participants and their context and the role of my supervisors. Moreover, the relevance of this study can be argued as it adds to existing knowledge on the role of the PHN in rural areas (Mays and Pope, 2000).

3.12. Limitations of the Study

The small number of participants involved meant that one must be cautious with the findings. When conducting any type of research, it is beneficial to carry out the research on a larger scale to allow a more comprehensive analysis. However, within the design itself the solicited diaries, and the semi-structured interviews proved very useful in
gaining in-depth and meaningful data from the participants, thus allowing the researcher to gain an invaluable insight into the participant’s role as PHNs in rural areas. Another limitation relates to researcher bias, which is always a risk in any type of research study. The researcher tried to be aware of and be vigilant of her own bias and discussed this with her supervisors. Although it is impossible to eliminate research bias, the researcher is confident, to have achieved valid findings, which could be used for larger populations. Furthermore, it could be argued that the type of data collected leave more room for interpretation, than for example numeric data would.

3.12.1 Delimitations

The researcher had insider access to the population sample, however there was no direct contact with individual participants; all access was mediated through the gatekeepers, the Director and two assistant directors to participants who had expressed interest in the research. None of the researcher’s own friends or workplace colleagues was included in this study. Selection eligibility criteria (section 3.5) may also be viewed as a delimitation for this study. Using the diary-interview methodology, the researcher-participant power dynamic was changed, with the diaries the researcher and the participant were at a distance from each other, which lessened the influence of the researcher, the PHNs had more autonomy to share what they wanted with the researcher, they could self-report. The role of the researcher was limited, therefore reducing the researcher’s influence on the data being gathered.

3.13 Conclusion

There should always be a line of cohesion between the research questions, the design and methods used to collect the data and the methods used to analyse the data; moreover, this line should be explicit to the reader. In this chapter I have provided an overview of the research in order to help the veracity and strength of the data collection approach and methods. This chapter has provided an outline of the research design employed and the principal research tool/s employed, namely the diary interview method. The use of CAQDAS was outlined in so far as how it benefited the researcher in the organisation and storage of data and with the analysis process using Braun and Clark’s Framework (2006) as a guide. The methodological approach discussed within this chapter formed the basis of the research findings which will be presented in chapter four.
Chapter 4 Findings

4.1 Introduction

This study aims to explore the role of the Public Health Nurse in the rural areas of Kerry and Cork. The role of the PHN has grown in importance considering the shift of care from the acute sector to the primary care setting and that the PHN service is the only universal nursing service in the community area. Although, previous work has looked at the role of the PHN, insufficient attention has been paid to rural areas. The study is designed to remedy that weakness by adding to the knowledge base.

Data analysis took place with the use of Braun and Clarke (2006) framework of analysis as a guide, which is outlined in detail in chapter 3. NVivo 11 was also used to store the original data and to organise the data to aid analysis. The data collected for this project were text-based diaries and audio-taped semi-structured interviews which contained detailed accounts of experiences, observations and feelings. The chapter begins with an outline of the diary return and completion rates, and of the demographic data before presenting the four main themes. For ease of presentation it is necessary to present the themes as separate sections. The data is presented in a thematic manner incorporating the qualitative type data generated from the diaries and open-ended questions in the interviews. Nonetheless, there is of course considerable overlap between certain themes and sub-themes and where appropriate these have been highlighted. In order of presentation the themes are: (i) the role of the PHN as a Clinician, Co-ordinator and Educator; (ii) the Challenges to the role of the PHN (iii) the Operative challenges in the rural area and (iv) Communication.

4.2 Diary Completion Returns

As noted in chapter three, there is always the potential for completion fatigue (Wiseman et al, 2005) among participants however this feature was not evident in this study. Thirteen out of a total of fourteen diaries were completed, with two entries over twelve days covering a six-week period. However, one participant after the first week of data collection informed me that she could no longer participate in the study. The participant’s main reasons for not completing the diary were that the PHN “couldn’t fit it in, working in a very busy area, very busy next week, has annual leave the week after”. Fortunately,
this was not the case with the other participants and the other candidates’ diaries yielded rich data; with one notable participant going well beyond the target of twelve days, completing twenty-four days data. Overall, the participants noted that they found diary completion to be time consuming with some candidates staying on late in the evening to complete due to their commitment to the study:

trying to discipline myself and try to do it at maybe the start of the week or the end of the week. But maybe in a very busy week I might have it rolled in. I tried to set a bit of time to do it, but I did find that bit hard. (Participant, Interview 10A)

All except one participant added in the interviews, the diaries acted as a reflective tool. The participants pointed out that completing the diaries was an opportunity to reflect on what they did and if what they did was beneficial to the clients. This reflection on their practice was rare and the majority of the PHNs enjoyed the experience. The PHNs also wondered what the researcher would think of what they had written. Interestingly, the one candidate who said she found it hard doing the diary, “Hard. I don’t like too much writing. I found it hard to put down what I actually wanted to put down and I found it laborious.” Nevertheless, produced a diary which gave great attention to detail.

4.3 Participant Profile

Fourteen participants were included in the study, seven from County Kerry and seven from County Cork, North Cork and West Cork due to the rurality of the area. Thirteen females and one male, all PHNs who had many years of PHN experience ranging from 7 years up to 27 years. The mean age of the participants was 45. All except one had dual qualification of midwifery, some had multiple qualifications in Sick Children’s nursing, intensive care nursing and neonatal nursing. Two candidates held a master’s in nursing. As this is a small community, and in order to maintain confidentiality and with respect to the participants, the researcher did not present this in a table which you may see in other studies which would give you a more detailed attribution of qualifications and registration. As discussed in chapter three in to maintain anonymity, all PHNs will be identified by a number, anonymity will be maintained throughout, respecting ethical research guidelines, names of the research sites and that of the participants will not be divulged.

4.4 Main Themes

As discussed in chapter three, data analysis in this study was aided by the computer software NVivo 11. The data sources consisted of 13 text-based diaries and 13 semi-
structured interviews. All the data sources were analysed with the aid of Braun and Clark framework (2006) as outlined in detail in chapter 3 through which, four main themes were generated and identified. The core theme from the data is the role of the PHN and three further themes are the challenges to the role, challenges in the rural area and communication.

4.5 The role of the PHN

The role of the Irish PHN, as discussed earlier in chapter two is a complex and multi-faceted one and not easily described. This was evident in the data as the broadness of the role became apparent through the analytical process. Nonetheless, codes that were similar in definition and content were merged. Similar themes were categorised and named. The findings recognise that there are three facets to the PHN role, that of the Clinician, the Educator and of Co-ordinator. The following figure 5 is a visual representation of the amount of time the PHN spends in each role, the figure is generated through the coding process with the aid of NVivo 11 from the diary sources.

![Figure 5 The Role of the PHN](image)

As discussed in chapter two, section (2.8) the increase in life expectancy and our increasingly ageing population have led to an increase for the need for home nursing services, which has increased the demand for clinical nursing care on the PHN service and the depletion of their preventative role. Figure 5, reveals that greater than half of the PHN’s role in this study, was spent on clinical nursing care doing home visits, assessments, wound care and care planning. Approximately one third was spent co-ordinating/managing the care of the clients/families in their care and less than a quarter
was on educating clients, families, parents, home support staff and students including nursing and medical students. A presentation of thematic data in further detail will follow.

4.5.1 The Clinician

PHNs as generalists have a long history of providing high quality clinical care to people in the community. It is essential to understand that most people wish to be cared for in their own home surrounded by their familiar possessions and their own family. From the diary sources, PHNs described the variety of clinical nursing situations they were involved in such as supporting and caring for clients who are unwell, clients recovering at home post-surgery and those who are at the end of life. Home visiting to new parents and infants and new-born screening, child welfare and protection was also seen as an important part of the PHN’s clinical role. Joint home-visits between PHNs and palliative care nurses and/or community mental health nurses, were evident but limited due to the wide expanse of the area.

4.5.1.1 The workload of the Clinician

PHNs use their clinical skills to assess, plan, implement and evaluate their clients’ care in partnership with the client, carer and family. From the diary data, the clinical workload of PHNs involves, providing wound care, urinary catheter care, palliative care, supportive visits to families and clients, first visits and follow on visits to mothers and parents of young children, surveillance/follow up of vulnerable clients, facilitating independence and promotion of self-care through, assessments for home help, homecare package reviews, involving a multiplicity of client groups across the life-span. Excerpts from the interviews which gave further insight will also be used in the following paragraphs. PHNs, gave insight into the need to support families, “being there” for them.

Supporting families is huge. People now caring at home are struggling, in our area anyway, we have an elderly person with an elderly spouse, family working, and may not be nearby, so be it the nurse or the GP it’s multi-disciplinary, home helps, you’re supporting them, be it advice... Whether they want to look after their person at home, their family member or they want to get respite, or they want to go into long-term care. You’ve to support them and advise them and it’s going to be different for every family. (Participant, Interview 9A).

I think one of the biggest jobs in our nursing roles is supporting families, because sometimes the actual patient is well looked after. Their day to day needs are met. But the families need a huge amount of support. (Participant, Interview 8A).
The PHNs spoke about creating a partnership with families and empowering carers who are looking after clients in their homes and how challenging that can be. Often families are stressed and overburdened trying to balance their caring role towards their partner or parent with their everyday lives and the PHNs are on the receiving end of this stress. PHNs are a front-line service and see what materialises first-hand and seemed to act as counsellors to emotional relatives either in person or on the phone.

It can be stressful and you’re dealing with families that are stressed out... obviously when they need... and their condition is deteriorating. You could spend a lot of time on the phone apologising! (Participant, Diary 5A).

Offering emotional support can ease the burden of care on families and enable them to continue in their caring capacity, as noted from the data: “it’s a very important role and like that again, it’s probably something that you can’t document, and you can’t see” (Participant, Interview 9B). As one PHN said “they will have no front for a nurse. You see it as it is.” (Participant, Interview 7A).

All the PHNs described wound care as a significant part of their clinical workload.

I suppose the wound care is a big part of our day. We have people that have surgery now and they’re discharged from hospital very quickly whether it is after... or reconstructive surgery or whatever it is. So, they’re home very early on with vats and Pico dressings and obviously we have the age group from young accidents right up to the older age group, the regular results and then you’d have them posted into surgery and obviously post cancer patients and mastectomies and all that. They’re all coming out of hospital much earlier and it’s putting a big demand on your time. (Participant, Interview 4A).

To facilitate independence of their clients in meeting their self-care deficits, PHNs frequently mentioned home help assessments and reviewing homecare package to enable and empower clients to remain in their own home.

home visit to do Csar Hep [sic]20 review, maximum dependent pt., family requesting a block of time “unfortunately we don’t have that service” carer as housebound as the mother, 10 hrs a week “does not want to go into one of those places” frequently, DGT pays a private carer to sit with her mam one day a week so she can do the shopping. (Participant, Diary7B).

PHNs spoke about liaising with families who have a member with mental health issues, and how limited they are in their professional practice, in that they cannot refer directly to the community mental health nurse who could visit this family at home, only the General Practitioner. However, it is incumbent then on the family to take this person to the GP which can be extremely challenging and difficult. It is worth noting that all CMHNs21 can refer directly to the PHN service.

20 Common summary assessment review, homecare package form
21 Community mental health nurses
Phone call from father, concerned about his son “talking about the other thing” advised re Gp for immediate r/w, son refusing to go anywhere, hx of alcohol and violence against father, advised re Gardai if necessary, at the end of the day all I could do was to direct him to GP. (Participant, Diary 10A).

From the diary data, the other clinical nurse specialist that was evident in the rural area was the palliative care nurse and collaboration and joint visiting with this nurse was apparent, often meeting the client together to build a rapport and relationship with the client and family as demonstrated by participant, 4A;

I think they’re, in particular with palliative care, they’re really beneficial, palliative care don’t provide a service of home nursing needs assessment, so you’d be going to do the nursing needs assessment and palliative care would give you the background. Mostly they know how much intervention. It’s nice to introduce yourself to them, if you’re going to a patient that’s dying with a syringe driver, it’s terrible not to know the family.

With children, PHNs illustrated their clinical role in child welfare and developmental milestones monitoring, home nursing and child protection, this encompasses home visits to children with chronic illness and those with varying needs. Support, encouragement and reassurance is required by all families. For, a parent looking after a child with a life-limiting illness, the PHN ensures that they the parents are aware of all the support services and encourage parents to accept that support. PHNs are cognisant that they are designated child welfare officers and act accordingly:

If there are any child protection issues we have to address them and we have to liaise with our duty child protection officer and social work referrals even though they are not common place for me in this particular area, but we still have to take our role very seriously and would be involved in cases from time to time. (Participant, Interview 7A).

PHNs can find this difficult at times due to the nature of the relationship with the family as described in the diary data and interviews which will be outlined in more detail in the next section.

4.5.1.2 Nature of the relationship

The nature of the relationship between the PHN and the client is infinitely different than that to the nature of the relationship between the patient and that of a hospital nurse. From the diary data in the community, the PHN enters the client’s home and remains a visitor in their sphere as illustrated in the following quote:

We want as Public Health Nurses to be able to visit the homes. We are visitors in their homes. They have an entitlement to ask us to leave if we overstep the mark in their eyes. We cannot go to the house and tell people what to do. We can make suggestions that we hope will help them but it’s their choice whether they decide to accept our intervention or not. (Participant, interview 10A).

There is a shift in power; the client is much more assertive in their own home and much less likely to conform than in a hospital setting. Respect and flexibility in the PHN service
helps to establish a therapeutic relationship with the client and promotes security and well-being.

home visit to 85-yr-old man who has chronic COPD on continuous O2, son main carer, home environment poor, refused home help, show me the door, if I keep going on about it, will accept meals x 5 days, equipment supplied bed commode. (Participant, Diary 1A).

PHNs felt they are perceived as having all the answers by the community they work within and are the first port to be called upon in a storm.

any people in the community think that the Public Health Nurse should have the solution to everything and they come to the Public Health Nurse before they go to the doctor because often times they don’t want to bother the doctor but they will come to the Public Health Nurse because they feel more comfortable with the Public Health Nurse, especially in a rural area Well any area people get dependant on their Public Health Nurse and they expect the Public Health Nurse to have all the answers, even more so than the TDs sometimes. (Participant, Interview 1A).

As clients are community- based living in their own homes, client-centred care becomes a priority for the PHNs which will be portrayed in the next section.

4.5.1.3 Client-centred care.

Caring for a client in the home environment re-enforces the concept of treating the person instead of the disease and in delivering person-centred care. The PHN’s relationship with a client or a family may be a lengthy one particularly those with a chronic condition. This enables the PHN to gain an understanding of the client’s needs and helps clients to accept their share of responsibility for their health and to focus on enhancing the client’s strengths. The care therefore becomes more client-driven and strengths-based. PHNs feel they are trusted and respected and are called upon to intervene by families.

Family of 3 siblings with a progressive degenerative condition, cared for by elderly parents, parents requesting PHN to talk to one who was refusing hospital review with consultant neurologist as they were worried re him falling, he agreed following discussion with PHN, mother very grateful for the PHNs time. (Participant, Diary 9B).

For the clients who suffer from self-neglect22, the PHNs are a lifeline they cannot do without. PHNs will continue to offer a service and call on these clients, even if client is reluctant to accept care. For example, Participant 3A outlines this in the following paragraph;

I would imagine this is a very common scenario with the vast majority of Public Health Nurses. Self-neglect is a very common phenomenon that would be prevalent in every care area. This particular client has on-going wound care needs and despite the implementation and the

22 Self-neglect is described as a person’s inability to provide for oneself the goods or services to meet basic needs (Day 2012)
PhNs seem to be ideally placed to recognize pending signs of crisis and to take appropriate action to prevent unnecessary hospital admissions. As shown in the data, PhNs feel a responsibility an "onus" to follow up on vulnerable clients and as co-ordinators in their area liaise with the appropriate services available to support these vulnerable clients. The co-ordinator role will now be described in the next section.

4.5.2 The Co-ordinator

Public health nurses take twenty-four-hour responsibility for the clients in their care in their specific geographical area. Nursing people in their own homes requires a skill set that is very different from caring for people in a hospital setting. PhNs have confidence in their decision-making and have a creative and problem-solving approach to deal with the many varied issues they encounter daily.

4.5.2.1 Caseload management

PhNs, spoke about caseload management concerning a variety of care groups which included management of the nursing calls and designation of same as appropriate. Calls were prioritized based on the acuity of the client’s needs. It is clear from the data that many of the clinical nursing calls were carried out by the PHN in the rural area due to the distance travelling and the lack of support staff. The participants reported that given the geographical disparity and the limited access to resources, PhNs operating in rural areas are faced with a set of challenges that are not encountered by PhNs operating in urban areas.

In a lot of areas, the Public Health Nurses tend to deal with the health side of it. We don’t have that privilege down here the other side of the coin is our support staff, RGNs, come from a particular area. You can’t be driving them from A to Z if you’re doing the whole area. It would be absolutely, not possible to divide up calls in the day. So that’s why we end up contacting the families ourselves in our own areas. You might be going to area A today and you’ve a first visit there, so you are actually going to be doing that cohort of people today even though it’s in the remit of the RGN to complete it. I think we would be very much in charge of all or our caseload, not just.... I think we’d all have equal input in that. That’s dictated to a large extent by the rural area. (Participant, Interview 7A).

Also highlighted in the management of their caseload, were the following: facilitating hospital discharges at short notice; dealing with complaints, liaising with external
homecare agencies; organising and cancelling respite services and liaising with the home help organisers.

4.5.2.2 Care co-ordinators

PHNs are the key care co-ordinators in the primary care services and liaise with all HSE services, as noted by participant 9B diary entry “liaise and refer to all members of the MDT”. Other services which the PHN liaise with include voluntary services, external care agencies and with council and government representatives. PHNs use an interdisciplinary approach and cooperate with other organisations based on how complex the assessed client’s need is. With the main aim being to ensure that the client in their care gets the appropriate service in a prompt manner. This point was well made by participant 4A where they noted that:

I suppose a huge part of this role is you are essentially a care co-ordinator. You’re aware of what support services are available within the community”. Living in a rural setting, the volume of services wouldn’t be as such in a city or a large urban centre. But that is a large part of my role, going out and assessing what the particular needs of a family are, making recommendations, submitting applications, whether that be home help services, making recommendations for whatever equipment is needed from a moving or handling point of view, or to support anything else (Participant, Interview 4A).

PHNs wrote in their diaries regarding taking phone calls/letters from government/council representatives advocating on behalf of their clients on a regular basis. Whilst some PHNs welcomed this, others viewed it differently as illustrated by this quote from an interview with participant 9B:

we would be involved in liaising with other agencies, such as T.Ds who write letters, make phone calls, expecting a service to be put in because they think it’s a good idea and all the ins and outs of how to go about that and it’s very sad to think that a T.D.’s letter is seen as something threatening instead of being seen that it is highlighting an issue, maybe for somebody

On the other hand, one PHN felt it was a political game with many public representatives ringing about one individual, all requests being similar in nature and often the PHN would have already asked for the service by the time the T.D. had contacted them:

I suppose we get regular calls from a TD, because in our area the TDs are very closely aligned to each other, because they’re vying for votes and they’re all trying to help the vulnerable, but they all seem to speak to every TD, not just one TD. Four or five letters about the same problem. And I do recognise that the TD is an advocate for the client, trying his best or her best. But in most circumstances when they’re looking for something, we actually know what they’re looking for, because we’re the first hand, we have it done, and we have got what we can within the realm of the hours that we’re able or beds available. (Participant, Interview 1A).
PHNs also voiced their frustration at the way a service is delivered in the community i.e. (delivery of incontinence wear to homes) and their lack of control, over the deliveries even though they are the personnel that sanction it in the first instance post assessment. This was a service which was local, where the family or carer could go to a health service community store to collect this incontinence supplies but now is centralised and is delivered directly to the home. In theory there is a presumption that this would be more convenient, however due to unpredictability of the need in the community the supply does not meet the demand leading to lots of difficulties as the deliveries are not frequent and may be every two months in an area. Families can get impatient and upset during the waiting period and the PHN often must deal with the fall-out resulting from situations that are beyond their control and responsibility. But as the first line of the HSE so to speak, they become a lightning rod for the families as illustrated by these two quotes:

Delivery of incontinence wear, client missed delivery, interim delivery not sanctioned, family irate, eventually after another phone call delivery agreed, PHN get the “brunt of the emotional turmoil that goes on in families (Participant, Diary 6A).

The bottom line is all down to budget really and it can be very frustrating if you have a new client, certainly with my line manager they won’t do interim deliveries now anymore. It’s down to you have to ring the family and say “look, I’m really sorry, but they are sanctioned, you have to wait six weeks before they are delivered”. The family can find it very frustrating and you’re there trying to explain to them, this is as it is. And they say then “can you not just go and collect them yourself?” and you have to tell them this is as it is. (Participant, Diary 7A).

Half of the participants were operating within a primary care team, and those that were, appreciated the support they obtained from their colleagues especially those caring for clients with complex care needs. For example, interview data of participant 9A, states that:

it is very important that we collaborate with other disciplines in the form of multi-disciplinary team and I’m very lucky to be currently working in an area, where the Primary Care Centre is new .... four or five years and it’s very much a collaborative process. We work very closely with the general practitioners who are also in the same building and there is a range of other disciplines that work here, so it is a base for other disciplines to come to use the office space like a dietician or the chiropodist.

Also, that working collaboratively within the primary care team, not only benefits the PHN but also the client as illustrated by participant 9B’s Interview:

it’s all positive and we’re supporting each other because we’re coming at each other from a different point of view, like coming at things from a nursing and clinical point of view, say an occupational therapist is coming at it from a completely different point of view. We share information and I think it’s important for clients that they see that we actually don’t work in isolation, but all together for the benefit of the patient.
Whilst the GP in the literature as outlined in chapter 2 (2.6.4) is often regarded as the central figure of the primary care team, one participant 5A advocates that it is the PHN is the key figure with meetings cancelled if she (PHN) can't attend:

Oh, I think it's fantastic. They say the GP is the pivotal role but actually, I have found that if the Public Health Nurse isn't able to attend the meeting, the meeting is not carried out because the Public Health Nurse knows everything. She’s the integral part, not saying we’re better than... but that’s what’s happening in our area for the GP. But we have a fantastic one here with physio, OT, dietician, SW, mental health. We have a good set up here.

4.5.2.3 Advocacy

PHNs spoke about being an advocate for all clients but overwhelmingly families with children with special needs came to the fore. PHNs spoke about “fighting for services” for clients especially those with disabilities. The supply of services to meet the needs of these families is not easily available or acquired. Also, it was made clear, those who transition to adulthood with a disability seem to be overlooked as illustrated by this quote from participant 3A (interview): “You spend a long time outside being their advocate, fighting for services for them due to the ever evolving HSE and the changing of movement to another area. You have to follow up with them”.

PHNs voiced their concern at the lack of services for people with disabilities who are transitioning from child to adulthood and their feeling of “uselessness” as there is no HSE service or agency that they can refer to for a service.

You have to think outside the box and to work around services sometimes, it would be lovely to think that every child transitioning to adulthood with a disability, with aging parents and siblings that have their own lives or whatever, that the State would look upon them kindly and look up on giving services to those people kindly. (Participant, Interview 9B)

4.5.2.4 Hidden role - lack of clerical support

All the PHNs voiced their dissatisfaction at the lack of clerical, administration and maintenance support staff at their health centre, and that PHNs take up the shortfall because there is no one else to do it. As PHNs they do a lot of what one PHN called “hidden work” the work done behind the scenes. Due to the lack of clerical staff, an amount of PHN time was “wasted” on non-nursing duties. All the participants felt it was not part of their job description, and one PHN stated that their clients were not receiving value for their money when PHNs were doing tasks that could be carried out by other personnel if available. PHNs felt that it was not their job to be organising maintenance
but absolutely not, the ordering, the stores, the lifting heavy boxes. It’s absolutely crazy. We shouldn’t be doing. Most of that is being done every day, the posting, the scanning, the paperwork, whereas at least if we had clerical support, you could put all your bits. You are allowed to use her, but it means... all your stuff. She doesn’t come to base so you’ve no regular support. (Participant, Interview 5A).

Two PHNs, who worked from a primary care centre and had some secretarial support, stated they still spent much time liaising with people who were looking for directions and experienced on-going interruptions during child-health clinics, and how much time was “wasted” on such interruptions.

4.5.3 The Educator

As a PHN, health promotion and educating individuals, families and communities is an essential aspect of their role as outlined in the job description circular 41/2000 (DOH, 2000). In the study PHNs spoke regarding educating clients and families, rather than health promoting therefore this facet of their role was called the educator. The PHNs outlined their role with clients on an individual level (micro) and in group settings (meso) and how their role involved educating home support staff, student nurses and medical students. Furthermore, the PHNs expressed the opportunities available to them to continue their own professional development.

4.5.3.1 Individuals and Group

One PHN talked about her educator role, as automatic and not doing it consciously when visiting clients and how it involves all her client groups. The importance of educating clients to self-care, to maintain independence and to encourage clients to adopt healthier lifestyle behaviours was paramount. It is worth noting that PHNs were actively discussing with their clients, how their lifestyle behaviour maybe contributing to their ill-health. Parent education was seen to be valuable and worthy and it is evident that PHNs use home visits and formal child development appointments as opportunities to promote health.
regarding nutrition, immunisations, emotional and psychological as well as the physical development of children.

I suppose we do it all the time without realising it ... I’ll be promoting breast feeding, promoting the wellness of the mothers So, we’ll be doing from the birth until the older age really. Subconsciously yeah. Because if somebody is sick you’re saying why are they sick? How’s your diet? Are you drinking enough? We are doing it all the time. (Participant, Interview 5A)

It would be paramount then to go visit these people. It’s not a social visit and it’s not a surveillance visit. It is health promotion at its core to keep people well and at home. (Participant, Interview 9B).

you’re never benefitting someone if they have an illness if you’re going to be pussyfooting around. What you need to say in a kind of constructive way and always remembering our health promotion activities, because it is a major part of our job. (Participant, Interview 6A)

Group education was evident and involved running breast feeding classes, parenting groups, carer support groups.

...carers are very vulnerable in isolated areas, so I set up a carers support group. We have about 25 members.... So, the group meets every second Thursday. It’s only an hour and a half on a Thursday. but we have some ground rules and that is, the first fifteen minutes they spend venting their frustration at whatever is going on, but after that they have to stop... it’s for the carer, not the person they’re caring for. (Participant, Interview 10A)

Antenatal education classes were run outside of normal working hours to facilitate expectant parents in the area. All the PHNs mentioned promoting and educating parents re- breastfeeding and running breast-feeding support groups in their local rural community. All were aware of how important this would be for parents and in one area where the breastfeeding group was not running, plans were in place for it to commence.

“Breast feeding support group, new mums and babies, they may attend the breast-feeding group once or twice or may attend it several times. It all depends” (Participant, Diary 1 A)

4.5.3.2 HSE Staff and Students

PHNs described arranging education for family and training of support staff so a client can be cared for at home. Three PHNs talked about the preceptorship/supervision of student nurses and medical students and saw it as a role they valued, a two- way process where the students could learn from their experience but also that the PHNs would be informed by the students.
I’m happy to impart my knowledge and I’m happy for them to impart their knowledge. It’s a good learning process. I’m happy to do it and I suppose recognition of it, not recognition as in a pat on the back, but recognition within our professional role. (Participant, Diary 8A).

Every year we have 4 or 5 students that we take turns in being their preceptor, though obviously if I’m a student preceptor, I introduce the student to our role more or less and arrange for them to go on specific visits. (Participant, Interview 8B).

Whilst the importance of educating students was evident so was continuing the PHN’s own professional development which will now be outlined.

4.5.3.3 *Continual professional development*

Continuing professional development was an important component of the PHNs role. PHNs spoke about participation in training and attending study days to keep up to date with the best evidence to ensure a high quality and safe delivery of nursing care. It was apparent from the PHNs that there was a co-ordinated structure in place in this area to promote continual education. One PHN described how the director in the area encouraged professional education and how it was readily accessible on a regular basis. Participant 1a in their interview stated that “well we’re very privileged in .... because our boss, is a great advocate of continual education. We’re upskilled every year on whatever we need to be, plus many more things. We’ve great access to continual education and funding our education needs”. These sentiments were echoed by participant 4A: “we actually have a good updating system, and it’s good because we are more or less told its compulsory, which is great, so you just don’t take the easy way out. You just go”.

Having outlined the findings on the three facets to the PHN role we will now lead on to the challenges to the role of the PHN.

4.6 Challenges to the role of the PHN

In the study challenges to the role were apparent, identified and categorised. This theme has four sub-themes, unpredictable workload, staffing issues, carrying the can and the environment.

4.6.1 *Unpredictable workload*

PHNs operate an open referral system, unlike other HSE disciplines there is no waiting list for clients leading to unpredictability in their daily work schedule. PHNs respond to whatever faces them in the community. The source of these calls varied and even though the PHN service is not an emergency service the PHN is often the first person to be called
if there is a problem in a home. These unplanned calls lead to a “knock-on effect” on service provision and meant that PHNs prioritise those in the greatest need. Some PHN’s seen this as part and parcel of the nature of their job, whilst others find it frustrating, which can often lead them to “pricritising the priorities” and the PHN going home late to accommodate all the calls. This frustration is well illustrated by the following three interview quotes from participants 9A and 10A respectively:

“One thing you can say about planning your day, it’s impossible in one way because you never know on the other side of the area what’s going to happen... we don’t have a waiting list”; [and] “even though we are not an emergency service, if somebody comes and asks you to help them...... You are going to deal with it because you can’t just send them off and say, you can’t do that” and

Generally, unplanned calls are very time consuming. It takes a lot of time. Obviously, you’re gonna have to make decisions as to who you’re going to defer, who you’re going to postpone and sometimes it’s not always in the best interest in the patient to do that. And also, it can be quite costly to do; you’ve to go back to that area, 30km out the next day. That’s expensive. It’s not the ideal way to do things.

4.6.2 Staffing issues

PHNs function in a system where there is no cover if someone is on sick leave or for annual leave. The PHNs in the nearby area are expected and do cross cover that area till she/he returns: “It’s fine for a day or two. Sometimes somebody’s off sick, it could be weeks. It’s difficult then to get your own work done and fill in for somebody else as well”. (Participant, Interview 7B) and “suppose the workload is such that you do need two people” (Participant, Diary 8A).

Additionally, the PHN in the rural area is expected to participate in the local school immunisation team leading to a shortfall in staffing hours whilst still maintaining the same caseload. The impact of this is highlighted in this study and PHNs spelled out that often they are going home late, tired and exhausted, “suppose you will get very tired. You go home in the evening tired, cranky. You get overwhelmed” (Participant, Interview 8B).

The PHNs described instances of high mileage, having no lunch and feeling that the workload was too much on their own; “I’ve been asked to cross-cover out of my area altogether, which is a lot further away, totally impractical situation because I would say at most a 100km round trip” (Participant, Diary 11A).

Not only did the participants feel that they were staffing issues in the rural area, the demand for the service was greater and that the PHN service often the only service
available, was left to deliver the primary health service, as one participant describing the PHN service as "carrying the can" for the other services. (Participant, diary 9B).

4.6.3 Carrying the Can

PHNs are well-known local identities and the first discipline to be contacted, regardless of what the need. They described themselves as the go between in a lot of services and often left to carry this if no discipline will take responsibility; with participant 9B stating "It’s frustrating that no service wants to know or take him on". PHNs continue to see clients if they are vulnerable and will not discharge them even if they are no clinical nursing need as participant 3A states the “SW for vulnerable adults have seen and assessed this client and discharged him (Participant, Diary 3A). PHNs expressed their annoyance at carrying out their assessment and recommending a service which is then not put in place due to budget restrictions and then having to explain this and continue to manage these cases.

And another thing is, any little thing seems to have to come through us. No matter what it is people seem to think they have to come to the Public Health Nurse. And everything comes back to us if it can’t be solved by any other discipline. It seems to land back to us. (Participant, Diary 9A).

It does seem to me that often, from my point of view anyway, that often we’re the go to person for an awful lot of the stuff as regards the virtual Primary Care team and ... Maybe I’m having a narrow view of that, but I do think at times that we’re the go-to person and we seem to be the first (Participant, Interview 8A).

Additionally, PHNs feel they are the only service available in isolated rural areas and there is more need on their service in a rural area due to the absence of supportive services and limited healthcare options. As a result, PHNs require a wide scope of knowledge and skill which may extend to other healthcare professions.

The awful thing about, it’s very difficult caring for somebody in an isolated area because you are the only one that is going to go there really and relieve the home help. The doctor is very slow to go. Everyone is slow to go. (Participant, Interview 9A).

In the rural area, if they don’t have a GP service locally, so they probably have more of a call on your service. (Participant, Diary 6A).

PHNs carry out the non-nursing duties not out of choice but because there is no-one else available to carry out these duties and if there are not done it is the PHN and the clients who would suffer. Again, as participant 9B stated left to “carry the can”.

A lot of those roles would have been inherited at the time, and the area is so geographically vast, you always have to embrace other roles other than your nursing. I mentioned bringing in the bins.
If I don’t bring in the bins nobody else is going to do it. With checking the oil during the winter, we don’t want to have a cold health centre. We come in on the Monday morning and if somebody isn’t there to check the oil, make sure there is enough heating. (Participant Diary and Interview, 3A).

Another challenge to the role of the PHN in a rural area is the environment that the PHN works in which will be outlined in the following section.

4.6.4 Environment

PHNs portrayed the rural environment as both challenging and beautiful, included in this is the work environment at the local Health centre. One PHN indicated the health centre environment as unsuitable for purpose, not allowing for ease of access to clients with mobility issues and those with young children due to the PHN rooms being upstairs and no lift available. One PHN (Participant, Diary 11A) tells us that the clinic room is not appropriate for wound care due to carpet furnishing on the floor.

Draw back in an old-fashioned, up a flight of stairs, many pts can’t access the PHN room as upstairs, t’s upstairs with no lift. So, anyone with a dressing needed doing can’t have it done up there and its tricky stairs even with people bringing their children up, lots of steps and around the corner. It’s two rooms.

The importance of the documentation of a client’s home environment was highlighted to maintain one’s own personal safety due to the challenge of managing animals, especially dogs in the remote areas as highlighted below:

if someone has a dog or a donkey in the yard that might come at you, so all the settings would have to be documented as part of your care plan. It seems funny to someone sitting in an office that this is something, “god almighty what are these ones at”, but this is the reality of working in rural Ireland. (Participant, Interview 9B)

Having defined the challenges to the role of the PHN, the following section will delineate how the PHN service operates in a rural area

4.7 Operating in the Rural Area

Operating in the rural area offered unique trials and tribulations to the PHN. This theme can be sub-divided into four categories, firstly services, secondly, time expended on travelling, thirdly, working in isolation and fourthly, transport, see Figure 6. Presents a visual representation of these challenges generated through the coding process using NVivo 11.
4.7.1 Services

PHNs emphasised that health services seem to be far away and not readily accessed in a rural area. This compromises the quality of service available to offer. PHNs stated that there is a waiting list for services, such as home help, which consequently leads to the burden of care to fall on families as Participant 7A’s Diary explains;

home help service is not in place, has been approved but there is a waiting list for same, not satisfied, on-going issue as we are at the front line and get the full impact of family’s frustration and anger on an on-going basis.

PHNs seem to get the brunt of the families’ frustration as described by Participant 8A “people get very cross with you that they don’t get what is necessary”. One PHN describes how a young person with a chronic illness/disability may not get the required services as they are living in a rural setting, “with the frequency of services such as the MS society would be able to see clients would be much less frequent than in urban areas.” Another, issue which is apparent is the reluctance of home helps to attend to neighbours even though they may be the only personnel available.

In this area noticed everything is far away when you work in a rural area, services centralised, stores too far away, often they or their carers don’t drive anymore, there is nobody to send to stores for common items required such as commodes or kylie sheets. (Participant, Diary 11A).

Not only are services far away in a rural area, from the diary data, the PHNs spent a considerable amount of their day travelling to their client’s homes.
4.7.2 Time expended due to travelling

PHNs discussed that due to time-consuming travel, less people were seen and the time available for care is reduced. PHNs felt it was important to be organised to minimise time travelling to offer a more effective and efficient service. PHNs described how in areas the road network being of such poor repair, that some roads are not fit for motor vehicles and could only be accessed on foot or by tractor. PHNs outlined this as another reason why at times home helps may be reluctant to take a position with a client due to the distance and time going to a home each day. However, the PHNs felt that their clients are as entitled to the visits and support as much as those who live on the main roads.

The one thing is you'd find you wouldn't get much work done, you don't as much in the rural area. I find that the journeys are long. The roads can be very bad. You're going to places sometimes that are quite isolated. You would be a bit nervous. The conditions might not be as good as in the town. (Participant, Interview 9A).

My area, I've a very long geographical divide. It's 26 km from end to end. It's a lot so you have to manage your time. So generally, I try on particular days of the week to do a cohort. You try not to be going back and forth. (Participant, Interview 8B).

As distance travelled can be long, PHNs work in isolation which will be discussed further in the next section.

4.7.3 Working in Isolation

PHNs described working in isolation as a lone worker and how they lack social support. All are lone workers and are a great distance from their base. Some, certainly not all, described their sense of vulnerability when visiting homes and the strategy they employ a buddy system to keep themselves safe. PHNs explained how they enjoy meeting up with their colleagues at the school vaccination programme and training days.

I am the only nurse for a long way, in the large geographical area. (Participant, Interview 11A).

You're way down on your social support, I suppose the nature of our job is that we're lone workers anyway, but you become a little bit more alone. (Participant, Interview 8A).

Definitely in isolated areas, you would feel vulnerable. I always have my phone on me when I go into the house and face my car for the road just in case I have to leave in a hurry. I'd always inform my colleague that I am going to this client that they are aware of where I am as well. (Participant, Interview 7A).

One PHN felt, open and vulnerable to accusations of inappropriate behaviour and more concerned with this than his own personal safety.
...it's probably a little unique that I'm a lone worker and that I'm also male. There are not too many men working as Public Health Nurses. So, I would be cognisant of that. I probably would be more aware of it from putting myself in a position of vulnerability, leaving myself open to accusation allegation as opposed to fear for personal safety (Participant, Interview 3A).

In addition to long distances and poor infrastructure, transport presents an added test to operating in a rural area which will now be outlined.

4.7.4 Transport

PHNs described how home visits were increased due to the lack of private and public transport in their areas. It also, impacted on the uptake of services by clients. Additionally, there was no one available in certain cases to send to stores to collect common appliances such as a commode as the clients or their carers don’t drive any more. PHNs arranged transport to hospital for clients due to no family member being able to drive.

In a rural area it’s not easy to get people to visit facilities, to come, whether it is day care or health centre or whatever it is. In the rural area you haven’t got that transport. It’s a huge problem. (Participant, Interview 4A).

One PHN stated she found it more efficient to do home visits instead of offering clinic appointments to young families, as they found it too difficult to attend due to the distance.

We have a large drive I do a lot of home visits to the young children, because especially the first year, out to twins far away, easy for me to call to them there and then. Then you got very little missed appointments. (Participant, Interview 11A).

PHNs describe even though they may have excellent day care services in the area, due to lack of transport for example the centre’s only bus available on certain days or a restriction on its mileage leads to limited uptake of this service.

We have an excellent day centre for Alzheimer’s patients and Dementia patients not too far away from here. They have transport but that only encompasses so much of the radius of where the centre is and there are Alzheimer or Dementia patients living at home living just 10 or 15 km further on and then trying to get to the service, because they have no transport. So, you see, it’s a constant battle in relation to something... (Participant, Diary 9B).

One PHN describes how a young person with a chronic illness or disability may not get the required services as they are living in a rural area. PHNs consider the financial costs involved if no public transport available when referring clients to services.

Transport is obviously a problem and wheelchair accessibility to be bringing these people back and forth to clinics for physio and things, I’d say that’s one of the biggest challenges in the rural area, are those suffering from disabilities. (Participant, Diary 4A).

a taxi ride can be expensive. Where I’m working it’s €20 to get a taxi to Killarney. If they need wheelchair it’s €25. That’s one way, not two ways. Actually, to impress upon them about going
to a course, a clinic or an appointment, you have to take in the financial factor of the clients as well. (Participant, Interview 1A).

PHNs who had previously worked in urban areas, in relation to their own transport expressed the advantages for them personally working in a rural area were, that they did not have to worry about getting their vehicles stolen or obtaining parking fines. The following two quotes illustrate this point very well: “The one thing that’s good about it is, on the other hand, when you get out of your car, you don’t have to worry that it’s going to be stolen” (Participant, Interview 9A) and “Parking tickets aren’t an issue”. (Participant, Interview 3A).

Having given the findings to the role of the PHN and outlining its challenges and how it operates in a rural area, the fourth theme communication will now be described.

4.8 Communication

This theme can be divided into three categories, ICT communications, hospital discharges and the local network of Communication. The findings regarding communication have a two-pronged approach, communication was found to fail due to lack of knowledge regarding hospital discharges and secondly, due to the absence of availability and application of technology. An area in which communication was constructive and affirmative was within the community itself “the bush-telegraph”.

4.8.1 ICT communications

PHNs described the lack of computer access in their health centre and having to travel 26 kilometres to a bigger health centre to access e-mails or even go 11 kilometres to send a fax.

Unfortunately. I find emails I’m always late... It’s not practical at all where the computer is, and the manager would say to put it in an email, order it if you’re on the phone. You can’t do it the same day or adjust orders. That’s a bit of a drawback. (Participant, 11A).

One PHN spoke about the ICT equipment in her health centre and how out-dated it was in that the photocopier “might take you 5 minutes to do 2 copies, with opening and closing the lid, so that was totally unsatisfactory, because that’s all we have, took five minutes to do one copy.” When there was no computer in the health centre, one of the main ways of transmitting information was through fax. “I have a fax machine, which we look after very carefully”. All PHNs have mobile phones supplied by the HSE but they have no internet
access and therefore cannot be used to access information or send and receive emails. A typical example is the Nokia 2600.

PHNs voiced that mobile phone coverage was a problem and how that impacted on their day in that a lot of their phone calls had to be made before they left the health centre in the mornings. One PHN spoke how the lack of mobile phone coverage affected her day when she had an accident. Some of the PHNs articulated that they carry their private phone with them as the coverage depends on the network you use, and they can operate their private phones as it is a different provider.

You have to be very careful because we ran out of petrol a few years ago and I was on a call coming down a hill with the ice. I thought I wouldn’t make it down the hill and no coverage. I really learned a great lesson that day. It was Christmas Eve and 12 a clock and terrible time (Participant, Interview 4A).

Most PHNs in the study were very anxious to have access to computers in their health centre, but it was not always easy to obtain same and when they did there was no training on its use and no back-up if any breakdown occurred.

we've been looking for a computer and we weren’t being given it and we were told we didn’t need it even despite the fact that not only do we need it in today’s technology age, we’ve students coming here and a lot of stuff you have to look up on the run plus the faxes and the waste of paper. All this. Finally, got it there not too long ago. We got a lap top alright. It was delivered into us. There was no training given. We were more or less told get on with it. It’s now broken for 2 or three weeks ... repair and nobody’s come near it. I suppose the help and support around training and maintenance isn’t there and I suppose again it’s a waste of money. It’s kind of hard to deal with stuff like that (Participant, Interview 8B).

The majority of PHNs were in favour of being able to access communications technology, there was one PHN who gave the impression that having access to emails as being extra work, adding a further load to their job.

Anything like that is just creating more work for the Public Health Nurse, especially in an area like this. It’s extra work. No matter which way you turn it, it is extra work. I really don’t have time to be checking emails every day and... (Participant, Interview 10A).

4.8.2 Communication between Acute Hospitals and PHNs—hospital discharges

Communication between the PHN service in the rural area and the acute hospitals overall was poor. Hospital Discharges was the subject of much dissatisfaction to the PHNs due to the lack of communication. PHNs were often informed by family members that the client was home without any prior notice from the hospital, despite many clients needing a lot of support, putting the PHN service under duress.
Phone call from family member, re hospital discharge of a relative with a CVA, rt sided weakness, no discharge summary received from...this has happened on a number of occasions” reflection pt can be “discharged on a Friday with no plan” very challenging for the PHN “staff in hospital only concerned with the bed and don’t plan beyond it. (Participant, Diary 6A).

Late referrals from the hospitals, direct attention to physical needs and crisis management reducing the quality of care delivered. PHNs were critical of the lack of planning and communication from hospital discharge co-ordinators from the acute hospitals.

I think as time is going on and as people are becoming discharged from hospital much faster, that seems to be happening, not just a regular referral but from … or maybe somebody coming out of the discharged policies. I am critical of discharged policies. The idea of sending home people on a VAC, very poor discharge planning is dreadful. They’d ring you at 3 o clock on the Friday to say they’re home for the weekend and they’re in pretty bad shape and who’s going to be doing their wound and this and the other and getting worse. (Participant, Interview 4A).

The poor communication between the acute sector and the primary care services leads to lack of continuity of care for the client and shows us that the service is far from the goal of an integrated service.

Moreover, PHNs described the hospital discharges as getting more complex and given the fact they receive little or no information on their clients, PHNs spoke about having to self-educate themselves so they can provide the necessary clinical care required to the clients for example on how to do certain clinical dressings.

They’re getting more and more complex. We have things that we’ve never seen before and when somebody comes out of hospital we don’t always get a proper discharge, dressings we’ve never see.... you really are left nearly to look it up online. There’s no other way of doing it and teaching yourself. (Participant, Interview 9A).

4.8.3 Local Network of Communication

From the diary and interview data it was clear that the PHNs had an informal system of communication in place, PHNs declared this as a real positive in the rural area. The PHN was well known in the area, even if they didn’t always know the clients and there is that sense that the PHN will be approached if there is a problem. One participant 11A described the PHN as a “light wandering around the rural area” The PHNs gave the impression people living in the rural area knew who they were and if they needed the PHN for assistance they knew where to find them. Knowing a lot of the families in the area, was cited as being advantageous when offering support, the PHNs could find out a
lot of information informally, local organisations and services were very visible. While the previous section highlighted the importance of modern communications technology the personal touch is still deemed to be a crucial element of the role as illustrated by this quote from participant 10A diary: “a lot of business can be done just walking down the street”.

PHNs encouraged and supported the community to be active in taking ownership of health issues by attending face to face meetings with local voluntary rural organisations firstly to act as a catalyst to help resolve issues and concerns and secondly to discuss any resources they may be able to offer which could benefit the local community. The PHNs were able to help the community better understand that their own abilities may be their best health resource.

We have monthly meetings with the IRD as well and everybody knows each other, the nurse and the St. Vincent De Paul and being a rural area, everybody knows each other anyway, but you would have a good idea and I suppose there are advantages of being in an area for 5 or 10 years that you do get to know what family... (Participant, Diary 6A).

After that I got in contact with the rural social scheme and arranged that at the time of any storm, the nearest person in the rural social scheme would call to her and check that she had water, gas, food and just make sure she was ok. That is going to continue regardless. (Participant, Diary 1A).

One PHN felt the local community looked out for her and each other and kept her updated on any happenings in the area which created a good community spirit.

The local community want services in their area, so they’re looking out for me...... They use their knowledge to inform me about things, which is fantastic.... I have unlikely work people to get things done or tell me about the patients and who tell me if there are problems or tell me of any news happening. I’m not expecting ...the team around me, I don’t know.... but seem to work for the good of their neighbours and so on and this is very helpful. (Participant, Interview 11A).

Whilst it is clear the local rural communication network helped to enhance the PHN service, it was plainly evident that there is substantial need for improvement in ICT and between interprofessional communications.

4.9 Summary

This chapter presented the qualitative findings on the role of the PHN in a rural area which is the main aim of this research. This study had a sample size of 14 PHNs, which represented a small sub sample of PHNs working in the region. The researcher acknowledges that the findings need to be interpreted with caution when attempting to generalise them to the PHN service, because the data set has limitations due to sample size that need to be taken into consideration when attempting to draw conclusions from
the study's findings. The setting was in the rural area regions of County Kerry and North and West Cork.

The qualitative data was obtained through participants’ diaries and semi-structured interviews. The diary data revealed what the PHN did in her professional capacity; it also showed the variety and diversity of her role. The participants diaries contained the PHNs own personal reflections which enhanced the richness of the data. The semi-structured interviews helped to consolidate and verify what was in the diary data and gave the participant the opportunity to add new data. The core findings of the study are that the role of the PHN in the rural area is threefold that of a Clinician, Co-ordinator and Educator. The challenges to the role of the PHN, that are apparent are the unpredictability of the PHN workload, staffing issues, PHNs are the only service in the rural area “carrying the can” and the work environment. Operative issues that were revealed in the rural area are the availability of services, transport matters, the time expended on travelling, and working in isolation. Communication was another theme that impacted on the role of the PHN in rural areas, and was categorised into the following; hospital discharges, ICT and very much a positive for the rural area the local network of communication.
Chapter 5 Discussion

5.1 Introduction

In this chapter the findings of the study in relation to the research question, as well as the aim will be discussed, how and why the research was carried out will be outlined, what the findings are and what was congruent with the literature and what was unexpected. This study set out to explore the role of the PHN in rural areas in Cork and Kerry: consequently, the research involved PHNs who were working in this rural region. The research data was attained through participants’ diaries and semi-structured interviews.

To summarise the data, the role of the PHN has three facets one of a Clinician, Co-Ordinator and Educator. Challenges to the role of the PHN was also apparent in extent to the unpredictability of their workload, staff resources issues and to the point that the PHN service was “we’re it”, the only service available. Operating in a rural area also brought its own trials such as time spent travelling, transport issues, working in isolation and privation of services. Communication was a major theme identified in the data, which impacted on the role of the PHN in the rural area; when it was poor or non-existent it inhibited the PHN service but when it was good it facilitated the PHN. The chapter will begin with a discussion on the meaning of the role of the PHN and the significance in its broadness/universal role. This will then lead into a discussion on the challenges to that role and the issues arising operating in a rural area. The chapter concluded with an examination of the role that communication in general, and ICT in particular plays in the administration of the PHN role.

5.2 The Broad nature of the role of the PHN in a rural area.

This section provides a discussion based on the perspectives and opinions the study participants had on the role of the PHN in a rural area. In chapter two this theme of the broad role of the PHN was discussed. Findings, from the study participants, indicate that their role is complex, multifaceted and difficult to define. It was commonly felt amongst the participants that their role was a universal one and that of a generalist. From the diary-data a comprehensive, diverse and wide-ranging list of clinical, co-ordination and educative skills were outlaid which displayed the expansive role of the PHN as a Clinician, Co-ordinator and Educator. PHNs were shown to be flexible, versatile and creative in their caseload management. This was very similar to Hanafin’s description where she outlined the threefold role of the Irish PHN to be that of a clinician, manager
and Health promoter (Hanafin, 1997). It was also clear from the narratives of the participants that PHNs interact and provide care to all individuals and groups on the lifespan continuum which also is coherent with the current job description of a PHN (DOH Circular 41, 2000).

At this present time there is on-going debate and a number of recommendations have been made (McKenna and Kenny, 2004; Clancy et al, 2013; Pye, 2015) regarding a move towards greater specialism in the PHN’s role rather than maintaining the generalist aspect as discussed earlier in chapter two (2.9.1). It was evident in the data in the rural area that the complexity and diversity of care provided would be very difficult for a PHN to operate without the skills and knowledge of a generalist. The PHN could make one trip out from their base and maximise the total clients’ care delivery in that area. The literature supports this finding the; rural PHN needs to be all encompassing, use a primary health care approach in order to meet the needs of all the community not just one entity (Francis and Chapman, 2008). Additionally, the PHN who operates in a rural area has a great distance to travel, five participants stating they travelled a total of 100-120 kilometre daily and because of the PHN’s broad skill set and knowledge could encompass all the care needs in a specific area on a particular day, favouring the retention of their generalist role. Their generalists’ skills may be in fact be their specialism, which has been discussed in previous literature (Scottish Executive, 2006) and would mirror what other general nursing colleagues are achieving in the acute sector, such as the Acute Medicine Nursing Certificate (Casey et al, 2015). The “Jack of all trades” theme was mentioned by just one participant only, compared to previous studies where it was a central theme (O’Sullivan, 1995; Begley et al, 2004) suggesting the PHNs may have moved on and began to value the profession for its inherent strengths and its uniqueness.

This study supports the literature that the increase in need for clinical nursing care is outweighing the preventive/health education role (NDPHN and Shannon, 2014) as outlined in chapter two (2.8), in that approximately over half of the PHN time was spent on clinical nursing/curative care, whilst approximately a third was spent on health education activities. Whilst clinical care needs did take precedence, primary prevention and health education is an important part of the PHN’s role in rural communities and there was evidence of this in the participants practice both at an individual level and at a group

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24 NDPHN is the National Directors of Public Health Nursing.
level, giving the example of participant’s 9B diary data; “at every opportunity we would try to do a health education activity.” PHNs described it as “worthwhile” work and as automatic in their role as they look at the whole person holistically. “Because if somebody is sick you’re saying why are they sick? How’s your diet? Are you drinking enough? We are doing it all the time.” (Participant, Interview 5A). This, holistic care is comparable with the findings in the Galway study where PHNs had capacity to see the “big picture” (Begley, et al, 2004). The nature of the client-nurse relationship as explained in chapter four (4.5.1.2) facilitated health education to the clients on an individual basis as the clients trusted and respected the PHN’s knowledge. Evidence from the literature, reports that the interpersonal skills of the PHN and her/his ability to build a relationship with the client is an important aspect of support when trying to change a health behaviour (Glanz, Rimer and Viswanath, 2008).

5.2.1 Staff resources

Staff resources were a significant issue identified by the participants that hinders the delivery of care by the PHN service. The system that PHNs operate in, is one where the participants state there is no staff cover, if someone is sick or an annual leave and that cross-covering of other PHN areas was a common feature in the study. This point is illustrated through participant 6A:

We don’t have a substitute if she doesn’t come. It’s just up to me. I’ve been asked to cross-cover out of my area altogether, which is a lot further away, totally impractical situation because I would say at most a 100km round trip, if I have to go into the area.

This is unlike the acute sector where relief/agency staff can be sought at short notice. Findings from a recent study by the INMO (2013) supported similar findings and found that 87% of respondents indicated that relief staff were not employed to cover sick leave or holidays, and this clearly has implications for how the service is delivered in those areas. Demand for the service often surpassed availability with participants articulating there was work for two people. With participant 8A stating she “wished there was someone to share the workload with.” The impact of this described by the participants on the PHN is that they are overloaded, tired, exhausted and working beyond their weekly schedule. For example, this point was well illustrated by participant 8B: “you run the risk of running into ill-health, so I will try and take 10 minutes in the car always. I suppose you will get very tired. You go home

Galway study denotes to the study carried out in 2004 in Galway on the role and workload of the PHN (Begley et al, 2004).
in the evening tired, cranky. You get overwhelmed.” Work overload of the PHN has been emphasised in previous studies (O’Sullivan, 1995; Evans, 2002). Cross-cover has been identified as a major cause of work overload by the INMO study, with almost half of respondents (47%) stating that they ‘often’ provide cover (INMO, 2013). When working conditions are poor, increased stress is placed on the individual PHN, which in turn cannot support effective client care or the retention of staff (DOH, 1997; Evans, 2002; WHO, 2003; INMO, 2013; WHO, 2014).

The shift of healthcare from the acute sector to the primary care (DOHC, 2001b) has led to the increased clinical demand on the PHN service, as discussed earlier in chapter two (2.8); - however, there was no evidence in the study that any extra staff resources/supports had been put in place or suggestions that this was planned from the participants. Figures from the NMBI (2017) show that out of the number of PHNs who are eligible and registered to practice, that there was only a minimal increase of 24 extra PHNs registered since 2012, (2,402 in 2012 - 2,426 in 2017). However, it is worth noting that the figures illustrated do not show how many PHNs are actively employed by the HSE, for example the total number of PHNs employed in 2014 was 1,488 (NDPHN and Shannon, 2015) and in February 2018, was 1,483 (HSE, 2018a). In CHO 4, where this research took place, the total number of PHNs is currently 211, showing a decrease of 3 from February 2017, (HSE, 2018a). These figures illustrate how dissimilar policy and practice reality can be, when the core objective of Irish health reform is to achieve a more balanced health service by ensuring that the vast majority of patients and clients who require urgent or planned care are managed within primary care, while ensuring services are according to the National Service Plan 2014 (HSE, 2013 p. 35):

> to deliver safe and of the highest quality, responsive and accessible to patients and clients; a highly efficient and represent good value for money; well-integrated and aligned with the relevant specialist services sources.

This situation begs the question: how can this happen, if there are no extra resources put in place and the current PHN staff are overloaded as it is? To emphasise this point, Bryar, Kendall and Mogotlane (2012), outlining the work of the World Health Organization (WHO, 2008), stated that nurses comprise between 60% and 80% of the total health system and workforce, and provide 90% of all healthcare service. However, due to the

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26 CHO 4 is the name given to the community health organisation covering Kerry, North and West Cork and North and South Lee
rurality of the area, there were reduced resources, and consequently in the study there was a concern that the rural PHN felt they were the only service available, which led to an increased demand. This was not highlighted in previous studies (DOH, 1975; Burke, 1986; DOH, 1997; Government of Ireland, 1998; Begley et al, 2004; INMO, 2013; NDPHN and Shannon, 2014), on the role of the PHN however the research on the role of the Irish PHN in a rural area is scarce. However, a comparative study inclusive of Australia, USA and Canada involving PHNs/nurses working in rural areas would concur with this, where there is a reduced level of support in service delivery compared to metropolitan areas and that the PHN/Nurse describing themselves as the “We’re It” service (Bushy, 2002). Not only, in the study did the PHN feel they were the only service but also that they were known in the community which will be discussed in the next section.

5.2.2 Well-known identity

The fact that the PHN is well-known in the rural area differs from that of an urban area, as participant 4A explains; “I think people know who I am. I don’t always know who they are, but they’ll come up to me as if they know me and they’ll greet me in the street with you’re the nurse, aren’t you?” With this lack of anonymity, the PHN is far more likely to be approached first for their advice rather than a medical practitioner. It is not uncommon for the PHN to be asked health-related questions even when there are off-duty in a rural area. As participant 1A interview data describes it:-

They know my car and they can spot me up at someone’s house and say “oh you were in with... so and so. You have to be so careful because the eyes are everywhere.... confidentiality issue and the business of visiting and making sure you just have to keep it all politely under wraps, but I am known.

Because of the familiarity of the PHN with her clients, the PHN often has a close relationship with clients and other health care workers. This in-depth knowledge can be advantageous and can be used to assist her clients. The PHN is seen as a professional role model and has an increased status in the community. The literature denotes this as Social capital where there is a sharing of knowledge and resources between the PHN and community members because of increased trust (Lauder et al, 2006). However, there is an increased personal risk from disenfranchised members due to the high-visibility of the PHN (Winters and Lee, 2018).
5.2.3 Working in isolation

Despite the PHNs well-known identity and an appreciation by the community, there was a sense that as a lone worker PHNs can be physically isolated due to the rurality of the area and professionally isolated due to the scarcity of co-workers as revealed in chapter 4 (4.7.3). This isolation led PHNs to feel vulnerable at times, as they missed the companionship and support that urban health centres had to offer. The participants who worked as part of the immunisation team in the local school stated they enjoyed working as part of a team, participant 10A stating “great to work as part of a team as normally you are a lone worker”. This is echoed in the literature where being part of a team, interacting with nursing colleagues and a sense of belonging all helped to increase job satisfaction and helped to retain staff in a rural area (Hegney et al, 2002; Hanafin and Dwan O’Reilly 2015). Job satisfaction or dissatisfaction did not emerge as a major theme in this study but there was an overall sense that they enjoyed their job as participant 7B expressed; -

This is impossible to quantify what we do. People on the outside that are not on the front line just could not understand the role, the complexity and the variety of our job unless you’re here on the front-line practising. But I love it. I hope I do a good job.

The isolation was lessened by the PHNs who functioned within a primary care team. The PHN acknowledged sharing of information and care of clients beneficial and supported them in their role, as outlined in chapter 4 (4.5.2.2). This study highlighted the need to further expand primary care teams to all rural areas. Professional peer support is vital and needs to be further developed, as illustrated by participant, 5A (diary entry) stating the sector monthly meetings;

as very valuable as working in an isolated area and may feel unsupported, only time you may see the ADPHN, up-dating session any concerns are discussed, social support very important, you usually come away with more work to be done!

As stated in the literature clinical supervision is an opportunity that can enhance support and lessen professional isolation (O’Dwyer, 2012).

5.2.4 Continuing professional education.

The PHNs commitment to continuing professional development and education was clear in the study, by attending training sessions and study days. There was a consensus amongst the participants that it was imperative to attend these study days to keep up to date with practice development to offer effective care to their clients. Furthermore, there was momentum from the PHN management to attend where one participant 4A stating;
"you really are encouraged to go, it’s easier if you go". There seem to be a culture of lifelong learning as there was recognition that care needs were changing increasing in complexity. Participants had the awareness that they are professionally responsible and accountable for the quality of care delivered and need to be able to offer best practice. Additionally, participants welcomed student nurses/PHNs and medical students to their areas and were actively involved in preceptorship and mentorship. Participants spoke about it as a “two-way” process with the sharing of information between the student and PHN. This contrasts with the Galway study where PHNs did not see the education of students as part of their role and there it was mentioned briefly and unfavourably (Begley et al, 2004). This begs the question, could this contrast be directly linked to the previous section, did they value that interaction and social contact/companionship more from students as they work in isolation in rural areas?

There was no mention in the findings regarding advanced nursing practitioner or specialists' posts by the participants, but there was recognition that the care in the community is becoming more complex as discussed in chapter two. This was especially evident regarding children with life-limiting conditions where the HSE/DPHN have provided a paediatric nurse to support the family as part of that client’s homecare package. PHNs would continue to be the co-ordinator of care for the client and would liaise with the paediatric nurse depending on the client’s need recognising the need to stay within her scope of practice. There, was some evidence of joint visits with the other specialists’ community nursing members, the palliative homecare team and the community mental health nurse. The palliative team were more likely to be contacted if a client had pain. However, the palliative care team firstly would have to receive a referral from the client’s GP not the PHN, which is the same also for the community mental health nurse who only see people with a diagnosed mental health issue under the care of a psychiatrist. A PHN cannot currently directly refer a client to these specialist colleagues. Paradoxically the PHN cannot refuse a referral regardless of what the source is because of the open referral system in operation. This will be explored in the following section.

5.3 Open referral system

Participants in the study reported an open referral system which has been brought to light in other studies and reports (GOI, 1998; Begley et al, 2004) which differentiates from other primary health care providers who operate a fixed referral system. PHNs operating in this open referral system have no influence on the demand on its service, leading to
inconsistency and fluctuations in their workload. Some referrals are inappropriate, and the participants expressed the view the client is referred to them when there is no other available option as mentioned previously in this chapter (5.2.1). It was evident that the PHNs felt that every referral for an individual/family regardless of the client’s need came through them making them a “catch for all” service as described by participant 8A.

PHNs do not have a waiting list, cannot refuse a referral in the same way a hospital ward can, leading to an unpredictable workload and prioritisation of calls occur daily, using the priority guidelines outlined by the NDPHN, (2011). Attention must be drawn here to the fact, that all PHNs in the study were dealing with paper referrals and that the allocation of calls was hand written into a diary. There was no electronic spread sheet such as e.g. Access, Outlook, Adastra, System One, RIO, that are used in the UK, to tell the service who was due a visit. This leads the service open to human error and vulnerable to a client been forgotten or missed (Queen’s Institute, 2014). The upside for the client is that the service is highly responsive often the PHNs seeing the clients on the same day as referral received based on the need. Participants in the study reported carrying out their assessment of need of the client/family and recommending a service if necessary to support this client. The PHN will then continue to review the client as devised by the nursing care plan. However, the “crux” of the problem here lies in that the service the PHN has recommended is not immediate, there is a waiting list for that service such as occupational therapy, or for example home-help, may not be put in place due to budget restrictions, leading the PHNs to continue to manage and co-ordinate the case without additional resources. Participants, report this as very trying as families can get very emotional waiting for support and it is the PHNs who get the brunt of this frustration as they are the front-line staff of the HSE. The PHN acts as a buffer between the services and the client/families (Zeitz et al, 2006). The next section will discuss the services available and the current issues that were drawn attention to in this study that impede the PHN service.

5.4 Support services

From the diary data, it is clear that PHNs are the key to ensuring the delivery of appropriate services in the rural region. A key attribute of the rural PHN is having the knowledge of the available resources and how to access them for clients. The home-help service is one of the key home supports offered by the PHN based on the client’s assessed need. Some clients in the rural area were reluctant to receive this service and didn’t want
"strangers" coming into their home and it took some time on behalf of the PHN to encourage clients to accede. Leipert and Anderson (2012) report with the close-knit culture within rural areas, it can be difficult for other people/outside to be accepted. The Scottish Executive Report (2006) which found that people preferred one person visiting the home rather than a variety of different personnel. There has been an increased demand and supply of home-help and homecare packages as discussed in chapter two (2.8), over the last decade (HSE, 2016). Nonetheless, it is evident in the study that supply of home-help service does not seem to meet the demand. It appeared to be the norm that there was a waiting list in the rural regions. One participant (3A) described a person waiting over two months to be discharged from hospital, because home support could not be put in place. The participants gave the impression that this was a common occurrence across all the rural areas. Overall, there seemed to be a concerted effort by the HSE to obtain resources with outsourcing of work in the home-help service to private care agencies. However, it was noted by the participants that the private care agencies also had problems with the retention and recruitment of staff to rural areas with them cancelling the service at short-notice, leaving the PHN to contend with the client who now had no service. For example, this point was well illustrated by participant 4A’s diary

this is the 3rd case of short notice service cancellation in the area, required immediate attention as vulnerable client would need replacement of services, involved liaising with Line managers, Home Care Package Co-ordinator, and Respite Services.

Retention and recruitment of staff in a rural area has been reported as being widely problematic, (Hegney et al, 2002; Francis and Chapman, 2008)

The one area that was particularly emphasised specifically was the absence of services for people with disabilities in the rural area and the PHNs voiced being their advocate and "fighting for services". The number of people with a disability who are growing older is rising; of people reporting with a disability, the number of people aged 35 years and over with moderate, severe and profound intellectual disability has increased from 28.5% in 1974 to 49.3% in 2016 (NIDD, 2016). There are 10,679 people who will require alternative, additional or enhanced services in the period 2017-2021. Consequently, many of their carers, are also growing older and therefore their ability to fulfil their caring role is diminished, posing a further challenge to the PHN service. The census of 2016 recorded a 35% increase in the number of carers; almost 1,800 carers are aged over 85 years (CSO, 2016b). The lack of services for people who have a disability has been highlighted
nationally on the RTE programme, Prime Time recently by their parents and families (RTE.ie, 2017) However, why it has not come to light sooner or what is being done about it is not clear. It is evident from the data in this study this has been an on-going issue, and one which the PHNs were advocating for through their line managers and area’s disability managers, but it seems the “powers of be” were not listening. From this exemplar, it is suggested here that PHNs should be more political and truly are the people on the ground who know the services that are available and what are needed. This is echoing what Clark advocated that PHNs should become political activists (Clarke, 2004).

Poor road infrastructure and lack of personal and public transportation also, impacted on the delivery and uptake of services that the PHN offered in the rural area. Inability to pay for travel costs to avail of a service was an additional factor in the absence of affordable and adequate transport. Participants believed that there were far more services available in urban areas and those clients had easier access leading to an inequity in services to people who live in a rural area. There is a limitation here in that this belief cannot be verified through the PHN urban counterparts; however, the international data suggests a similar finding. In the literature, it is stated that rural communities are unable to provide the span of services needed by individuals and an inherent feature of ruralness at an international level is that clients must travel to obtain a service (Bushy, 2002, Mills, Birks and Hegney, 2010; Winters, 2013) which would seem to lend credence to the PHNs. Having discussed the support services available to the PHN, the following section will examine the indirect time expended on client care.

5.5 Non-nursing duties.

The participants reported a substantial time spent on what they describe themselves as non-nursing duties. Many of the PHNs have no clerical/reception staff at their health centre leading the PHNs to answer many queries not related to their field. It was evident that the PHNs in the study had asked for support and this was not forthcoming as illustrated by participant 7B;

I’m here 8 years. I have asked for clerical support here in the health centre. I have been refused it. We have clerical support in a health centre which is 15 miles away.

Ample time is lost on making out child development clinics, sending out appointments, posting these letters and of clients’ referrals. All the PHNs are responsible for ordering health centre stores and client specific orders and putting these away and informing clients
of their arrival. This extended to for example following-up on bed maintenance and hoist servicing. One participant’s diary data even described checking and ordering the heating oil at the health centre and being responsible for bringing in and taking out the health centre bins. When questioned on this in the interview, the answer was there being “no one else to do it” and if it wasn’t done it would be the PHN and the clients who would suffer. It would appear that the above is a “trap” that PHNs have fallen into, some have inherited the tasks from previous PHNs, where they continue to do the work of clerical/maintenance staff which should essentially should be done by others. This was highlighted in the Galway study where PHNs were patching up gaps in the service (Begley et al, 2004). A few of the participants had a somewhat conciliatory tone regarding the issues highlighted above of what can we do attitude. On the other hand, most participants were frustrated they were left with the non-nursing duties. Two, PHNs spoke how they would welcome an audit on what they did as they hoped it would show how “valuable PHN time is wasted” on non-nursing duties and highlight the shortfall nationally of clerical support to the service. One PHN stated it was not her job; she was “over-qualified” and saw the work as “meaningless”. Previous literature has highlighted the lack of clerical and secretarial support and the making up of shortfalls in the community service by PHNs (Timpka, Svennnson and Molin, 1996; Begley et al, 2004). Statistics has shown a decrease nationally in clerical staff in primary care areas with a reduction of 13% between 2003 and 2013 (HSE, 2014). With, the high demand on the PHN service this is certainly an area that needs to be scrutinised by the HSE community care management. A further theme that was identified is communication which will now be explored

5.6 Communication

As stated in the findings chapter 4 (section 4.7) the theme Communication in the rural area had dual components. There was evidence in the data of poor communication when it came to hospital discharges. Effective communication was noted within the rural area itself between the PHNs, clients, community members and co-workers. Overwhelmingly, the deficiencies in the ICT equipment availability both office-based and mobile are letting PHNs service down.

A key issue that was identified in the study is the lack of communication regarding clients’ discharge from acute care hospitals. Many PHNs stated clients were discharged without any communication from the hospitals. Some of these clients needed substantial support
from the PHN service in the form of pressure area care and hi-tech dressings. Some of these were discharged over the week-end on a Friday evening leaving families coping on their own without access to services. This point is well illustrated by participant's 4A diary data;

They’d ring you at 3 o clock on the Friday to say they’re home for the weekend and they’re in pretty bad shape and who’s going to be doing their wound and this and the other and getting worse.

PHNs felt that staff in the acute sector, see clients as a number and did not even think how the client would manage in their own home. In much of the cases it was the family member contacting the PHN service that the person was already home, as outlined by the diary of participant 6A;

Phone call from family member, re hospital discharge of a relative with a CVA, rt sided weakness, no discharge summary received from .... this has happened on a number of occasions, reflection pt can be discharged on a Friday with no plan very challenging for the PHN, staff in hospital only concerned with the bed and don’t plan beyond it.

This is reverting, back to the finding that the PHN in the rural area was well known and highly visible, as the family knew how and where to contact the PHN in the area. On the other hand, the non-acute community hospitals seemed to have a good rapport with the PHNs, where discharge planning meetings were held with the hospital clinical nurse manager, PHN, client and family representatives before a vulnerable person was discharged. These findings are identified in other studies on discharge planning where communication was variable, unsatisfactory to outright non-existent (Queen’s Nursing Institute, 2014; Hanafin and Dwan O’Reilly, 2015). However, there is an indication here, that the quality and safety of client care is being affected by poor communication between discharge planners and PHNs as inadequate time is been given to the PHNs to prepare, plan and organise the client’s care. Good discharge planning allows the PHN to integrate the HSE services with the voluntary community services to support the client. As argued in the literature, discharge is a period of high risk for clients if not organised correctly, leads to severe stress and greater readmissions (Queen’s Nursing institute, 2014).

As discussed in chapter two (2.8) poor ICT hampers the PHN service and has been recognised as an area in primary health care both urban and rural that needs improvement (DOH, 2013; NDPHN and Shannon, 2014). The findings in this study were consistent with the literature; however, the detail and the extent are worth noting how it affects the rural PHN. Firstly, although all the PHNs were supplied with a mobile phone for example Nokia 360, they were without internet access. As participant 11a describes it as a “very
basic mobile phone that you can make calls and texts, no internet at all”. Poor coverage and black spots were noted by half of the participants in their geographical area with one participant (9B) having to make all her necessary phone calls before she left the health centre “as no reception midway through the area.” One participant (4A) described how when she had an accident she had no mobile phone coverage to call for help, increasing her risk to her personal safety. Their work environment lacked ICT equipment; three health centres had no fax or computer. To gain access to their HSE e-mails, they had to travel to another health centre, which entailed a trip for one PHN of 26kms daily to keep up to date because of the lack of a computer in her centre. Another PHN expressed that the centre she worked out of didn’t even have a fax machine and she needed to travel 11kms to send a fax to organise equipment such as a profiling bed for a palliative patient. Technical support was lacking in the rural area, illustrated by the following; - two PHNs said they were given a lap-top after their persistence with management but received no training on it and when it broke after three weeks there was no one available to fix it. On the other hand, there was a reluctance on behalf of one PHN who had no computer to engage with ICT equipment as she looked on it as “more work” and stated she was too busy to access her e-mails.

It could be surmised overall from this study that instead of assisting the PHN, the ICT available is working against them. The e-health strategy (DOH, 2013b) identified that ICT needs to be improved across all areas of health care to safeguard an efficient and effective service. The strategy envisaged a digital dawn for health service providers. However, the evidence from the study suggests, it has yet to dawn in the rural areas. In the study, it is clear there have been limited advances in health information technology and in the availability of IT equipment to the PHN service. And moreover, there is inadequate technical support and training to PHN staff who have expressed an interest in its use. Attention is needed for provision of an enhanced and upgraded information technology system by the HSE which would ultimately lead to cost saving. There is limited reliable wireless internet signal/broadband as discussed in chapter two (2.8), in many rural areas where nurses are treating patients in their own homes - making systems that are dependent on internet access impossible to use. The latest figures available show that there are 840,000 premises awaiting a broadband connection (Oireachtas, 2018). Whilst it must be acknowledged, that the connectivity problems are beyond the control of the HSE, they are however entirely within the scope and future ambition of internet
service providers. The PHN service is not the only Public service in a rural area that is hampered by poor ICT, a recent report showed that 77 rural Garda stations had no access to the pulse system as they had no internet and they too had to travel to urban stations to gain access (Oireachtas, 2018).

An affirmative point and specific to the rural aspect of the role of the PHN, was the communication that existed between the PHN and the local community and was identified as a unique strength. One PHN felt because she knew the clients so well, she had a greater understanding of their health behaviours and the services available that her job was much easier. PHNs believed they could find out a lot of information due to the increased opportunity for informal interactions with clients and co-workers. PHNs were actively involved in meetings with local voluntary organisations and helped the community to develop services for themselves through their own resources. Lauder et al, (2006) advocate a collaborative approach to finding local solutions to community problems rather than the imposition of universalistic prescriptions. PHNs also had much more contact and a closer relationship with the home-help support staff as there was so few “as little as five” in one area. These findings are comparable with the international literature. (Francis and Chapman, 2008; Leipert and Anderson, 2012; Winters, 2013). PHNs, who were part of a primary care team which was discussed in section (4.5.2.2) has shown how beneficial face to face meetings can be with other members of the multi-disciplinary team. It would appear that the co-location of the PHN, GP and other health care disciplines would further enhance communication within the service. (O'Dwyer, 2012). This was one of the key proposals by the Primary care strategy (DOHC, 2001b) and has as the study shown this co-location has occurred to some extent in the rural area but needs further investment by the HSE.

5.7 Conclusion.

This chapter discussed the findings in relation to the primary aim of the research and its objectives. Primarily, the role of the PHN in rural areas is one of a Clinician, Co-ordinator and Educator. PHNs have a distinctive broad role and are a well-known identity and are generalists by the nature of their work and environment in the rural area. What is novel in the findings is that this study supports the retention of that generalist role and whilst it is known that the Irish PHN is unique, the data suggests that the PHNs in this study are more unique and should be called rural PHNs as the findings are very much aligned and identifies with a rural nurse internationally. In accordance with the research objectives,
attention was drawn to areas that were challenging the role; such as staff resources, working in isolation, non-nursing duties and the open referral system. The unique challenges identified facing the client are the lack of transport, poor infrastructure and the availability of support services. Communication in the rural setting was discussed and the extent of the use of ICT was outlined. Suggestions were made on how to lessen these obstacles. Before assuming new ways of practice or redesigning caseloads, consultation must transpire with rural PHNs in relation to the issues identified. To conquer the challenges outlined, there is a call a requirement and a responsibility by the HSE for implementation of the resources recommended by the Department of Health strategies to ensure that the PHN service operates in an efficient and effective manner to provide high quality and safe care to clients. Findings from this research on the role of the PHN and rural practice issues could be enriched by interviews with care recipients and their families and used to inform policy development and reform.
Chapter 6 Conclusion and recommendations

6.1 Introduction

This chapter concludes this thesis; it presents an overview of the study, focusing on the findings and a reflection on the research method, on the merits and limitations of its use. I will also reflect on my personal research journey. Finally, I put forward several recommendations, based on the data findings. The study, through its exploration of that role has made contributions linked to the existing knowledge and literature on the role of the Public Health Nurse in rural areas.

6.2 Aim and objectives of the Research

In concluding the thesis, it is worthwhile to first return to the study’s aims and objectives. The study’s primary aim was to understand and gain insight into the role of the PHN in rural areas of Kerry and Cork. Following on from this aim, I examined the following objectives:

- to identify the unique role that PHNs have in healthcare delivery in rural communities.
- to identify the unique challenges faced by PHNs operating in rural locations and the challenges that face clients from the PHNs’ standpoint.
- to inform policy around the delivery of Public Health Nursing in primary care in remote rural communities.
- to investigate the extent (if any) information technologies are being used by PHNs operating in rural settings.
- To provide an opportunity for PHNs to reflect on their own role through the innovative use of research diaries.

Results show that, the role of the PHN is threefold, one of a Clinicians, Co-ordinator and that of an Educator. Strengths for the PHN was the generalist role, the nature of the client relationship and the universal home-visiting service. The fact that the PHN had a well-known identity, people knew where to access the service and regularly called upon the PHN service first before that of their GP. Informal communication between the PHN and the community was apparent, and the PHN using this knowledge to build further collaboration within the community. Unique challenges, identified in this rural region that impinged on the PHN service were, time spent travelling, poor infrastructure, poor intra
professional communication, lack of resources in home-support staff and support services. An important finding within the study was the lack of clerical/ administrative staff on site to assist the PHN service and the amount of 'meaningless' work that PHNs were involved in. All of this inhibited on the health educator role of the PHN, which they saw as 'worthwhile' and an essential component of their practice. PHNs were actively involved in education of clients, carers, parents and nursing students. PHNs placed a high value on having the knowledge to provide a safe and quality service and attended study days and in-service sessions on a regular basis, furthermore there was an impetus to attend these educational opportunities by management. The clear lack of information technologies was evident, with no computers/laptops, smartphones, faxes in some health centres which impacted on a safe efficient and effective PHN service.

6.3 Summary of the Research.

The first chapter introduced the focus and context of the study, its aims and objectives of the research. Chapter two provided a review of the pertinent literature giving consideration to the historical and current understanding of the PHN’s role in Ireland; the review indicating that the role has remained broadly unchanged since 1966. The community nursing service, in Ireland has been subject to review and limited research at intervals since its inception in the 1960. There is a difficulty in comparison with international nursing profiles, as the Irish PHN is unique in that it covers all clients along the lifespan continuum with a curative and preventative remit (Clancy et al, 2013). Pertinent WHO and Irish healthcare policy and strategies influencing the PHN role has been introduced, as improving public health is at the forefront of all Irish, European and world-wide governments’ policies. Greater, emphasis is now on how best people can be helped to not just live longer but to stay healthy. PHNs are a universal service, who visits people’s homes and as Cawley and Mannix-McNamara (2011), describe as professionals who meet people in their homes where realworld health choices are made. PHNs are ideally suited and uniquely placed to respond to public health challenges as they understand the health risks experienced by individuals; and know the population and the communities they work in (Donovan, 2015). In the context of primary care reform PHNs play an integral role in delivering and treating clients in their home and is continuing to evolve to the growing demand for health care service in primary care.
The third chapter explained the study's methodological design, the rationale for the use of an ethnographic approach and its practical implementation. Ethnography is always concerned with studying culture and understanding the meaning of actions and events of people, mostly commonly it is described as interpretive inquiry and is acknowledged as the most basic form of social research (Hammersley and Atkinson, 1995; Crotty, 2005). The primary research method in this study was the diary/interview method (Zimmerman and Wieder, 1977) where solicited participant diaries were used in conjunction with interviews to gain a comprehensive picture and thus generate rich data. Given that the research sites are geographically disparate, the diaries enabled the researcher to effectively 'observe' in settings from which the researcher was absent (Elliot, 1997).

Chapter four presented the findings of the research; thematic analysis of the data was completed using the Braun and Clarke, framework (2006), which provides a method of identifying, analysing and reporting patterns within data, with the aid of NVivo 11. To synopsise the findings: the role of the PHN was found to be one of a clinician, manager and educator. Challenges to the role and operative issues in the rural area were identified. Communication was a recurrent subject which was identified and included as a theme.

Discussion of the study's findings and research questions, in chapter five puts forth several key considerations linked with the Role of the PHN in a rural area. The subsequent section provides my reflection on the methodology employed in the study and its limitations. It is acknowledged within the literature there are challenges with every methodology tradition (Creswell, 2014).

6.4 Study Limitations

It is necessary that any limitations in a research study are identified for the interpretation of the research findings to be credible (Polit and Beck, 2016). Consequently, the following limitations have been recognised:

- The study sample of participants were limited in size. Fourteen participants volunteered to take part that were in this CHO area, despite the quality and richness of data obtained being adequate, this should be included as a limitation as in terms of the overall PHN population Ireland it is small. It could be contended that in further exploration of the contribution of the study that a wider expanse of rural areas be incorporated and therefore a larger sample, to represent acuities of...
the wider PHN population. The study does not claim to be representative of the overall PHN population. Nevertheless, in the context of it being a qualitative ethnographic study, it does provide in depth rich data linked with the participants’ lived experience of being a PHN in a rural area.

- I am a registered PHN working within this CHO area. This situation can have bias effect on the research findings as the researcher’s own experience as a PHN may have an influence on the interpretation of the data findings (Parahoo, 2014). Nevertheless, as an “insider” I was cognisant throughout the research process that I remained reflexive of my own thoughts, beliefs and attitudes and accurately represented the data. The steps I took to minimise bias included; keeping a reflective diary, asking open questions in the interviews, participant validation of their own diary data, the researchers’ Supervisors member-checking that the interpretation of the research findings was concurrent with the data.

- The study looked at the role of the PHN; therefore, all participants that took part were PHNs operating in that region placing them at the centre of the research. None of the participants were community registered nurses or practice nurses, who also work in the community, as this study looked at the PHN role from the PHN perspective only, therefore it should also be included as a limitation.

- A further limitation linked to the research is that it investigated the PHN role from the viewpoint of the PHN only.

6.5 Recommendations

The PHN service is not only influenced by the needs of a community area but also by the level of other supports. For optimum delivery of care by the PHN service, it is evident that there is an urgent requirement for improvement. The, following sections, presents the recommendations for future PHN practice, policy and research based on the findings.

6.5.1 Practice

- That the PHNs operating in rural areas, who provide a broad-based public health nursing service retain their generalist status to meet the population needs. The preservation of that generalist role with a smaller geographical area/ caseload may be the preferred solution.
• Develop a criterion for referral to the PHN, so clarity can be increased and stop inappropriate referrals.

• Develop a health information system such as e.g. Excel or RIO which is used in the UK, (Queen’s Institute, 2014) for the referral system to the service, currently this is all paper based, which allows for opportunities of human error for the PHN service; so no called is missed due to human forgetfulness.

• Cross-covering of other PHN areas, both short-term and long-term needs to cease to reduce the workload burden on the current PHNs and improve the efficiency of the service.

• The amount of time expended on non-nursing duties by the PHN is not cost effective in terms of delivering client care in the primary care area. It is clear that clerical/administrative and maintenance staff are necessary to help operate the PHN service, so that the PHN expertise on preventative and curative care is optimised to enhance client care in rural communities.

• Intra-professional communication between acute hospitals and the PHN service needs to improve to enhance client care and provide a high standard of quality care to clients. A liaison PHN for each community sector, who would liaise with the acute hospitals daily would benefit and help to improve the significant problem of undisclosed hospital discharges and help to bridge the gap in communication between the acute care and primary care.

• The study recommends that no hospital discharge of a complex case takes place on a Friday evening without consultation with each party to ensure that a client and families and PHNs are fully supported. The Director of PHN need to advocate this with their colleagues in the acute sector for the PHNs and more importantly for the clients to ensure client safety and welfare.

• The Director and ADPHN in each area develop a model of clinical supervision, to support, recognise and encourage PHNs in their role to prevent the professional isolation of the PHN service in rural areas.

• The education and in-service training opportunities that were evident in the study to all the PHNs be maintained and encouraged.

• That the NMBI include in the education of all nursing students, the challenges and opportunities of working in rural areas in preparation for practice and to deepen
their understanding and what is warranted when they are discharging clients to the community setting.

- Expansion of Clinical Nurse Specialists and ANPs, from within the PHN service itself would further enhance the service as a PHN would already have the knowledgeable experience of managing caseloads within the home setting.

6.5.2 Policy

- A review by the HSE, to aid recruitment and retention of home support staff in a rural area, and an incentive/compensation programme by management for support staff, i.e. extra allowance for car maintenance due to the poor infrastructure, to ensure that rural clients receive an adequate service so that they can remain in their own homes.

- There is a need to develop a workload measurement system for use by public health nurses in Ireland that is capable of measuring the uniqueness of the role, many of the systems designed to measure workload are task based and do not capture the essence of the role such as decision making.

- Attention is needed by the HSE, to supply a more sophisticated software system and associated information technology. This includes, for example, the use of tablet computers or mobile devices so that the delivery of PHN services in the community can be supported. Information technology and its availability was limited, steps need to be taken by the HSE urgently for the supply of computers to all health centres to stop PHNs, using faxes as their primary route to transmit information and travelling miles to access emails. Access too for all PHNs to training with ICT would also increase their confidence and broaden its use. A technical support plan needs to be put in place to provide support to the PHNs in the primary healthcare areas for ICT when technology breaks down.

- That HSE management would use a population health needs approach and review the ratio of PHNs required in each geographical area, based on the client profile and demographics, so to provide an adequate skill mix to enhance and ensure the PHN service, make the best use of their knowledge and skills.

- That the HSE management recognise, specifically the PHNs unique knowledge of her clients’ needs, plus the availability and short-fall of services in the CHO area
and increase the PHN service involvement at the service planning stage, rather than merely at delivery.

- That the HSE, review the work environment/the health centres of the PHNs in rural regions and ensure they are fit for purpose, for example; remove carpet from flooring in clinical rooms, allow equal access to all clients by having clinical rooms on ground floors or installing a lift if upstairs.

- The HSE will continue to establish primary care teams as envisaged in the Primary Care strategy (DOHC, 2001b) to improve inter-disciplinary communication with the focus on the client and therefore the community it serves, and furthermore increasing the integration of services.

6.5.3 Research

- Further research on the role of the PHN, to include clients in the rural area to gain their viewpoint which would broaden the knowledge on the role of the PHN. This would facilitate a more depth understanding allowing for recognition of the needs and challenges of both PHN and clients in the rural area.

6.6 Reflection

I began this journey as a PHN who had eighteen-year experience as a PHN. As a researcher with insider knowledge, I acknowledge that for the PHNs involved in practice, that this study may not bring change in their circumstances. However, it highlights the uniqueness of the role of the PHN in a rural area and how comparative the findings are to the pertinent literature. One memory that I will retain will be the faces of the PHNs who were astonished, when I reminded them of their diary entries. It seemed they were so busy ‘doing’ their job, that they did not even realise, what the broad nature of their role entails. As the researcher, this for me validated the findings as it truly was the participants’ voice that was reflected by their data entries. This was consolidated through the semi-structured interviews.

Personally, I have developed both personally and professionally throughout this process. I have developed new IT skills such as power point and poster presentations and therefore are more proficient. I have had the opportunity to present twice at the IT research colloquium and have therefore become more confident at public speaking which will
influence my future practice as a PHN when giving antenatal/parenting classes. I have enjoyed the combination of research and practice and being an advocate for PHNs to enhance quality care. It has allowed me to produce actionable knowledge on what the PHN role entails. I look forward to the dissemination and presenting my findings to nursing management and at conferences.

6.7 Conclusion

This chapter has put forth the implications and recommendations linked with the study. My final remark is on completion of this thesis that the HSE see the rural PHN for the unique professional that they are and make available the necessary resources to ensure that their contribution to primary care continues and that clients living in rural areas have fair and equal access to health care. I leave with a quote from a participant 7B who sums it up as;

_The rural PHN is unique, not that we want to be treated differently, but we want to be treated differently because of our needs of our area. The people down here in the rural country area have different needs to the people of Dublin city. They are quite unique, the needs of the rural area. Not all live in the cities, there might be overlapping stuff, but we're not the same._
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Appendix A  Age Profile of each age group from census 1926 to 2016
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(1) Includes all diseases.
(2) Includes all neoplasms.
(3) Includes all neoplasms of buccal, bronchus and lung.
(4) For the age standardisation, among older people, the age group used 65 and over was used rather than separate age groups for 65-69, 70-74 and 85 and over.
(5) 2013.
Source: Eurostat (online data code: nhlth_cal.mortality2).
### Appendix B European health statistics

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</table>

(*) Inclusive heart diseases.

(*) Including the Netherlands.

(*) Including the Netherlands.

(*) For the age standardisation, among older people, the age group 85 and over was used rather than separate age groups for 85-89, 90-94 and 95 and over.

(*) 2013

Source: Eurostat (online data code: hltih susceptible)
### Appendix C International Comparison of the Role of PHN

<table>
<thead>
<tr>
<th>Country</th>
<th>Name Generalist or Specialist</th>
<th>Age Groups</th>
<th>Preventative Care</th>
<th>Curative Care</th>
<th>Governing Body</th>
<th>Work Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ireland</td>
<td>PHN (Generalist)</td>
<td>All ages</td>
<td>Yes</td>
<td>Yes</td>
<td>NMBI</td>
<td>Home, Schools and Clinics</td>
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<tr>
<td>UK</td>
<td>SCPHN-Health Visitor, Schools nurse &amp; Occupational Health nurse (Specialist)</td>
<td>11 days -6 years old, &gt;65, targeted groups</td>
<td>Yes</td>
<td>No</td>
<td>NMC, UK</td>
<td>Home, Clinics</td>
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<tr>
<td></td>
<td>District Nurse (Generalist)</td>
<td>All Ages</td>
<td>Yes</td>
<td>Yes</td>
<td>NMBI</td>
<td>Majority, Home visits and clinics</td>
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<td>Midwife (Specialist)</td>
<td>Prenatal -11 days old</td>
<td>Yes</td>
<td>Yes</td>
<td>NMBI</td>
<td>Home, Hospital, GP surgery</td>
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<tr>
<td>Country</td>
<td>Name</td>
<td>Generalist or Specialist</td>
<td>Age Groups</td>
<td>Work Environment</td>
<td>Governing Body</td>
<td>Curative Care</td>
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<tr>
<td>Canada</td>
<td>PHN</td>
<td>PHN (Speciality)</td>
<td>Targeted groups identified by the Provincial authority such as parent, child, adult, senior citizen</td>
<td>Limited home visits, clinics and schools</td>
<td>Provincial Nursing Authority</td>
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<td>USA</td>
<td>PHN</td>
<td>PHN (Speciality)</td>
<td>All ages</td>
<td>Communicable disease control, TB testing, immunisations, flu clinics, health education, driven by epidemiological evidence</td>
<td>National Council of State Nursing Boards &amp; State Authority</td>
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<td>Norway</td>
<td>PHN</td>
<td>PHN (Speciality)</td>
<td>Children, adolescents and families</td>
<td>Well-Child Clinics, School health services</td>
<td>Directorate for Health Affairs, four regional health authorities</td>
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Appendix D Distribution of nurses

Table of the distribution of registered nursing workforce in community and acute settings

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<thead>
<tr>
<th>Country</th>
<th>Community sector</th>
<th>Acute Sector</th>
<th>Other settings</th>
<th>Source</th>
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<tr>
<td>England</td>
<td>21%</td>
<td>54.7%</td>
<td>24.3%</td>
<td>NHS, 2012</td>
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<tr>
<td>Norway</td>
<td>32.3%</td>
<td>40.6%</td>
<td>27.4%</td>
<td>Norwegian Nursing Organisation, 2012</td>
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<tr>
<td>Ireland</td>
<td>5.1%</td>
<td>1,706 per 100,000</td>
<td>5,000 in private Hospitals and homes.</td>
<td>INMO, 2013; DOH, 2018</td>
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<td>Canada</td>
<td>40.6%</td>
<td>56%</td>
<td>13%</td>
<td>Canadian Institute for health information, 2012</td>
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</table>

Adapted from Royal College of Nursing, 2013 (updated December 2014). Moving care to the community: an international perspective. London: RCN
### Appendix E Gantt Timeline Chart

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<th>Stage</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
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<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
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</table>
Appendix F Participants information letter

Hannah Healy

Public Health Nurse

Killarney

Co. Kerry

086 XXXXXX//064XXXXX
Hannah.Healy@XXXXXXXX

Title of the Study: The role of the Public Health Nurse in rural areas of Cork and Kerry.

Dear Public Health Nurse,

My name is Hannah Healy and I am currently studying for a MSC in Research at the Institute of Technology Tralee. I would like to invite you to participate in this study.

The aim of the Research is to establish, understand and gain insight into the role of the Public Health Nurse in rural areas. The Research will use a combination of solicited diaries and semi-structured interviews referred to as the diary/interview method. Should you agree to participate you will be asked to meet with me, so I can distribute the diary at a time and location that is convenient to you.

Participation is confidential. The researcher will not disclose your participation in the study. No person will know what your answers are. Study information will be kept in a secure location. The results of the study may be published or presented at professional meetings, but your identity will not be revealed. Participation in this study is entirely voluntary and you may withdraw from this study at any time.

If you would like to participate, please read the attached information leaflet. The consent form must then be signed and either returned to me in person or posted to the above address. The first fourteen participants to respond will be selected.

I will be happy to answer any questions that you may have about the study. I thank you for taking the time to read this invitation.

Yours respectfully

Hannah Healy PHN.

Information Leaflet for Research Participants.
Title of proposed Research Study: The role of the Public Health Nurse in rural areas of Cork and Kerry.

Aim of the Study: the aim of the study is to establish, understand and gain insight into the role of the Public Health Nurse in rural areas.

What is the study about?
The study is concerned with exploring the role of PHNs in delivering care to clients in rural areas. The Study will gain insights into the approach and what the PHN’s role is. This will involve PHNs who are currently working with a caseload in a rural area.

What will your participation be?
If you agree to take part, you will be asked to complete a diary two day a week for six weeks. This will consist of your views and reflections on your day. Once the diaries are completed I may ask you to participate in an interview based on your reflections. During this interview I will ask open-ended questions, which you are free to answer in whatever way you choose. There are no right or wrong answers. The objective is to allow you to express your views and opinions.

What will happen to the information collected?
Once the diaries are completed, the diaries will be given code numbers. The information on these diaries will be read and common themes will be looked for. From this information I may then ask you for an interview to clarify your reflections to ensure the correct meaning is obtained.

Where will the information be stored and for how long?
Prior to transcription the diaries will be stored in the locked filing cabinet in the researcher’s office. The diaries will be given code numbers so that at the point of transcription will be anonymised. At no point will your name appear on the transcript. The researcher is the only person that will know who the number corresponds to and the researcher will not divulge this to anyone.

Who will have access to the information?
The only person who will have access to research diaries recordings is I and the supervisors.

At no stage will your name appear on the diary.
Are there any consequences if I choose not to be part of the study or if I want to opt out?

There is no obligation on you to participate in this research study. If you choose to participate you are free to withdraw your consent at any time. This means that you can opt out before during or after the diary completion. Should you withdraw the diary and any transcription taken place will be destroyed? Participation does not commit you to any further research.

Will people know I took part in this study?

I will not be informing anyone that you participated in the study. Your name will not appear on the diary or transcript. Information that might identify you will not be used in any publications resulting from this study. If you wish to talk to people about the study, you are free to do so.

Thank you for taking time to read this leaflet and for considering taking part in this study.

Should you require any further information please feel free to contact me.

Hannah Healy, PHN.

Email: hannah.healy@XXXXXXXXXX
Appendix G Consent by subject for participation in research study

Study Title: The role of the Public Health Nurse in rural areas of Cork and Kerry

Name of Researcher: Hannah Healy

Name of Supervisors: Dr. Tom Farrelly and Ms Sinead Flaherty

You are being asked to participate in a research study, to decide whether you want to participate or not you should understand enough about its risks and benefits to make an informed judgement. This process is called informed consent. This consent form gives detailed information about the research study. The Researcher can also discuss the study with you in detail. When you are sure you understand the study and what will be expected of you, you will be asked to sign this form if you wish to participate.

Nature and Duration of Procedures:

The aim of this study is to establish, understand and gain insight into the role of the Public Health Nurse. It will involve a brief meeting with the researcher and each PHN involved. At this meeting the researcher will disseminate the diary and give clear written guidelines on how to complete. participants will hold a diary and complete this diary two days a week for six weeks. There may be a follow interview with participants to clarify theme reflected in the transcripts.

Should you agree to participate, you will be asked to meet me at a time and location that is convenient to you always. The diaries will be seen only by the researcher and transcribed and analysed. The diaries will be coded on transcription. If you are chosen to be interviewed all interviews will be taped, transcribed and stored in an encrypted format on a password protection information technology system. You do not have to answer any questions that you do not wish to. This information will be retained for five years after completion.

Participation is confidential. The researcher will not disclose your participation in this study to anyone. No person shall know what your answers are. Study information will be kept in a secure location. The results of the study may be published or presented at professional meetings, but your identity will not be revealed. Participation in this study is entirely voluntary and you may withdraw from this study at any time.
Potential Risks and Benefits:

Benefits to subject and/or society:

There are no direct benefits to participation in this research study. However, participants will be given an opportunity to relate and to reflect on their professional role in delivering care to clients/patients in rural areas. It is hoped that this study will contribute to the body of knowledge in this area.

Potential risks to participants and precautions taken to minimise risk:

The researcher does not anticipate any potential harm resulting from participation. However, the study requires the participants to reflect on their own professional practice and what their role is, this may evoke an emotional response depending on the participants experiences. Information regarding the Employee Assistant Programme will be provided with the research study information leaflet.

Possible Alternatives:

You may choose not to participate.

Agreement to consent

The research project has been fully explained to me. I have had the opportunity to ask questions concerning all aspects of the project. I am aware that participation is voluntary and that I can withdraw my consent at any time. I am aware that my decision not to participate or to withdraw will not restrict my professional practice in any way. Confidentiality of records concerning my involvement in this study will be maintained in an appropriate manner. When required by law, the records of this research may be reviewed by government agencies and sponsors of the research.

I understand that the sponsors (Nursing and Midwifery Development Planning Unit, NMDPU and HSE) and researcher have such insurance as is required by law in the event of injury resulting from this research.

I, the undersigned, hereby consent to participate as a subject in the above described study conducted in Cork and Kerry Community Area. I have received a copy of this consent form for my records. I understand that if I have any questions concerning this research, I can contact the researcher listed above. I understand that the study has been approved by the Institute of Technology Tralee Ethics Committee and Gatekeeper access to the research sites trough the Director of Public Health Nursing in Cork and Kerry Community Areas.

I have read and understand the study

I agree to participate in this research

I grant permission for the data collected to be used in this study only
I agree to allow if interviewed that interview to be audio-recorded

I understand that my anonymised data will be stored securely for five years

Signature of study Participant:

Signature of Researcher:

Date/
Appendix H Draft Interview Questions

Draft for interview questions for candidate 9C

1. Demographic detail, qualification, how many years working in the area, Dual qualification, midwifery?
2. How have you found the diary process, did it help you to reflect on what you do?
3. Do you mind if we go through your main themes?

4. State what the main themes are from their diary and ask the question does that surprise you or does it validate what you said, is it a fair summary in your view?
5. From your own diary and with the analysis of the other diaries, the main themes are Care management, Health promotion, Children’s welfare, ........... Your diary one of the main themes was the home visits, home help assessments. Blood tests and the reliability of the machine and the amount of time you spend organising care for clients for example, Respite, home care packages, equipment.
6. Reading your diary, you talked about “the benefit of Knowing the Family”, can you add to that?

7. From your diary, you mentioned supporting families and carers, can you say a bit more about that, one of the cases was a sick child.
8. Unlike/ like other nurses from your diary you mentioned you had to make all your calls before you left the health centre, can you tell me more about this?
9. Tell me about working as a PHN in a rural area, what do you think are the main differences from an urban area? Have you worked in an urban area?
10. Do you think as a PHN that you must visit more often or less often to people in rural isolated areas?
11. You talked about attending a child care conference, talk to me about your role in Child Protection
12. You talked about “wasting nursing time” (in relation to putting an air mattress on a bed”,) not my job (answering knocks on door during clinics). talk to me a little more.
13. You mentioned cross-covering other areas, could you explain that a little further, is that something that is common?
14. You mentioned a complex case managed at home that may not be facilitated in the local hospital? Can you say a little bit more about that?

15. From your diary, you mentioned you are part of a primary care team and the positive relationship with the GP, what do you see as a strength/weakness as a PHN of belonging to a PCT
16. Reading your diary, you talked about the impact of unplanned calls on your day like other nurses, would you like to add anything else to that
17. What is the basic infrastructure like in this health centre and in the area as a whole?

18. Statement: Many of the themes identified in your diary could be similar issues to a PHN in Cork or Dublin city, do you agree with this statement, / how do you see it

19. Do you have any other points that you would like to add/ make?
Appendix I Reflective journal entry 18 June 2017

POST INTERVIEW CANDIDATE 5A

This was the third time in meeting with.... There was definitely a sense of relaxation in our meeting, maybe I myself was more relaxed which then influenced her, we didn’t seem to be on edge, and she didn’t seem to be as nervous. During the interview there was a natural flow to the conversation, she seemed to talk naturally about her role, her issues here. When I was giving her synopsis on her diary that she completed (which she did verify was hers) she truly did seem amazed at all the things she did as if she didn’t even realise. I don’t think she did. It makes me think that the diary completion was so important as without it I don’t think she would have given me half of it in an interview. Therefore, I feel hopeful that my research will be reflect truly the role of the PHN.